

The Experience of the AIDS Orphan in the Central and Eastern Regions of Ghana:  
Communication between Caregivers and Orphans Regarding HIV/AIDS

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By Elizabeth Lemons

The Ohio State University  
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Project Advisor: Dr. Walter Rucker,  
Department of African American and African Studies

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# Introduction

Although the HIV/AIDS (Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome) rates for the United States have remained steady for the last ten years at about 37,000 new AIDS diagnoses per year, HIV/AIDS has lost media attention as if the medications that make HIV “a manageable disease” have solved the problem altogether. My education about HIV/AIDS consisted of brief mention during the Sexually Transmitted Diseases unit in high school health class. Media attention to HIV/AIDS impressed upon me that the disease is an African problem. It was not until college that I realized HIV/AIDS is still a relevant issue in the United States. So why is AIDS often perceived as an African issue in the minds of American teenagers, who may be engaging in risky sexual behaviors with little sex education?

Certainly celebrity attention to the issue of HIV/AIDS in the form of the “(RED) Campaign” or the “I Am African” campaign have exploited the issue as a hip way for Western teens to show how cultured they are and to participate in paternalism in the form of compassionate consumerism. Despite the limited sex education of the American youth, Africans are still portrayed, both in the media and in some scholarly articles, more or less as ignorant tribal people who spread the disease through their archaic and uninformed sexual practices. Certainly, in some African countries the HIV/AIDS rates are dramatic, and the severity of HIV/AIDS in impoverished nations should not be minimized. After spending a summer in Ghana, I decided to personally investigate the issue of HIV/AIDS education by conducting interviews with members of one of the most vulnerable populations in Ghana: orphans.

## HIV/AIDS in Ghana

Ghana's HIV/AIDS rate is lower than the majority of West African countries' rates, and in comparison to a number of Southern African countries, Ghana's HIV/AIDS rate is low indeed. The first known case of HIV in Ghana occurred in 1986.<sup>1</sup> By 1992, there were a total of 6,009 cases of HIV reported, 68 percent of which were female. The rates are higher for women, because they are biologically and socially more susceptible to HIV transmission. In just a year's time, the number of HIV cases had doubled, and the number of AIDS cases had tripled.<sup>2</sup> Three quarters of the known AIDS cases were among able-bodied persons, aged 15-49, who made up the majority of the labor force. This age group also encompasses parents of young children. As of 2006, the percentage of the Ghanaian population living with HIV/AIDS was 2.3 percent, 55 percent of whom are women.<sup>3</sup> Women are generally infected at earlier ages than men. The mean age of death for women infected with HIV/AIDS is 25; meanwhile the mean age of AIDS-related deaths for men is 35.<sup>4</sup> The large number of early AIDS-related deaths has caused a reduced life expectancy statistic for Ghanaians, countering all development-related goals.<sup>5</sup>

HIV/AIDS on the African continent has only compounded existing problems such as civil wars, political unrest, poverty, debt crises, and economic restructuring programs.<sup>6</sup> In order to meet a mandatory condition for receiving funds from the International Monetary Fund and the

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<sup>1</sup> Ansah-Koi, Alice A. 2006. "Care of Orphans: Fostering Interventions for Children Whose Parents Die of AIDS in Ghana." *Families in Society: The Journal of Contemporary Social Services*. 87.4: 555-64.

<sup>2</sup> Anarfi, John K. and Phyllis Antwi. 1995. "Street Youth in Accra City: Sexual Networking in a High-risk Environment and Its Implications for the Spread of HIV/AIDS." *Health Transition Review*. 5: 131-51.

<sup>3</sup> Ansah-Koi, 556-7; Oppong, Joseph R. and Samuel Agyei-Mensah. 2004. "HIV/AIDS in West Africa: The Case of Senegal, Ghana, and Nigeria." *HIV & AIDS in Africa*. Ed. Ezekiel Kalipeni, Susan Craddock, Joseph R. Oppong, and Jayati Ghosh. London: Blackwell Publishing.

<sup>4</sup> Cohen, D. 1999. "Sustainable Development and the HIV Epidemic in Africa." *AIDS and African Smallholder Agriculture*. Ed. Gladys Mutangadura, Helen Jackson, and Duduzile Mukurazita. Harare, Zimbabwe: Fontline Electronic Publishing.

<sup>5</sup> Ibid, 6.

<sup>6</sup> Crentsil, Perpetual. 2007. "Death, Ancestors, and HIV/AIDS Among the Akan of Ghana." *Journal of the Finnish Anthropological Society*. 32.1: 54-62.

World bank, Ghana adopted a structural adjustment program (SAP), which resulted in increased poverty and urban migration, as well as reduced funding for HIV/AIDS prevention and educational programs.<sup>7</sup> The SAP worsened the existing conditions that enable HIV/AIDS to spread. In an impoverished country like Ghana, HIV/AIDS is more than a medical issue; it is a development issue. People infected with HIV/AIDS frequently cannot afford antiretroviral drugs.<sup>8</sup> In many places, the medical facilities are inadequate, and infections through improper use of needles and syringes are becoming more common.<sup>9</sup> In addition, widespread poverty and few wage-earning opportunities for women can lead to prostitution in urban areas.<sup>10</sup> HIV/AIDS rates are especially high among Ghanaian sex workers who travel to Cote D'Ivoire.<sup>11</sup> The common association of HIV/AIDS with prostitution has contributed to the stigma surrounding sexually transmitted diseases. Furthermore, the time lag between contraction and full-blown AIDS allows those who are infected to spread the disease unknowingly.<sup>12</sup> For those who are engaged in the practice of polygyny or serial monogamy, HIV is easily spread among partners.<sup>13</sup>

## HIV/AIDS Education

Since the mid 1980s, educational campaigns have been important for fighting the spread of HIV. Kwesi Yankah (2004), author of "Narrative in Times of Crisis: AIDS Stories in Ghana," writes,

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<sup>7</sup> Oppong and Agyei-Mensah, 80.

<sup>8</sup> Ansah-Koi, 557.

<sup>9</sup> Oppong and Agyei-Mensah, 77.

<sup>10</sup> Bujra, Janet M. 2005. "Women 'Entrepreneurs' of Early Nairobi." *Gender in Africa*. Ed. Andrea Cornwall. Bloomington: Indiana University Press; Oppong and Agyei-Mensah, 76; Wilson, Francille Rusan. 1982. "Reinventing the Past and Circumscribing the Future: *Authenticité* and the Negative Image of Women's Work in Zaire." *Women and Work in Africa*. Ed. Edna Bay. Denver: Westview.

<sup>11</sup> Ansah-Koi, 556.

<sup>12</sup> Ansah-Koi, 557; Barnett, T. 1999. "HIV/AIDS and the African Agrarian Crisis: Which Way Forward?" *AIDS and African Smallholder Agriculture*. Ed. Gladys Mutangadura, Helen Jackson, and Duduzile Mukurazita. Harare, Zimbabwe: Fontline Electronic Publishing.

<sup>13</sup> Takyi, Baffour K. 2003. "Religion and Women's Health in Ghana: Insights into HIV/AIDS Preventive and Protective Behavior." *Social Science & Medicine*. 56: 1221-34.

“National AIDS Commissions have been set up to monitor the spread and educate the public through media advertisements, pamphlets, seminars, focus group discussions, and several other modes of public education.”<sup>14</sup> However, several scholars note the lack of behavioral change among Ghanaians.<sup>15</sup> The Ghanaian government has even attempted to use the opinions of important leaders, such as local chiefs, Queen mothers, and elders to encourage behavioral changes in the population, but these attempts have not been effective.<sup>16</sup> A review of literature regarding HIV/AIDS in Ghana indicates that resistance to behavioral change can be explained by the consequences of widespread poverty, as well as cultural beliefs and values.

The variety of educational campaigns in Ghana spreads mixed prevention messages, which are heavily influenced by the ideology of the sponsor. The biomedical world promotes getting tested and using contraceptives, churches promote abstinence, and local customs promote practices that attempt to maintain the old social order.<sup>17</sup> Teye (2005) writes, “...the widespread use of condoms to prevent sexually transmitted diseases has made the word condom become morally and emotionally loaded with connotations of illicit sex.”<sup>18</sup> Because HIV/AIDS is associated with urban promiscuity, the idea that only estranged, promiscuous, or immoral people carry HIV persists, causing many to feel that requesting condom use calls into question one’s moral integrity.<sup>19</sup> Meanwhile, religious education campaigns that favor abstinence over contraception have intentionally led Ghanaians to believe that condoms are not 100 percent

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<sup>14</sup> Yankah, Kwesi. 2004. “Narrative in Times of Crisis: AIDS Stories in Ghana.” *Journal of Folklore Research*. 41.2/3: 181-98.

<sup>15</sup> Ansah-Koi, 557; Luginaah, Isaac N., Emmanuel K. Yiridoe, and Mary-Margaret Taabazuing. 2005. “From Mandatory to Voluntary Testing: Balancing Human Rights, Religious and Cultural Values, and HIV/AIDS Prevention in Ghana.” *Social Science and Medicine*. 61: 1689-1700.

<sup>16</sup> Yankah, 182.

<sup>17</sup> Grentsil, 59-60.

<sup>18</sup> Teye, Joseph Kofi. 2005. “Condom Use as a Means of HIV/AIDS Prevention and Fertility Control Among the Krobos of Ghana.” *Norwegian Journal of Geography*. 59: 65-73.

<sup>19</sup> Anarfi, John Kwasi. 2003. “To Change or Not to Change: Obstacles and Resistance to Sexual Behavioural Change Among the Youth in Ghana in the Era of AIDS.” *Research Review*. 19.1: 27-45.

preventative against transmission, enabling skeptical Ghanaians to continue having unprotected sex.<sup>20</sup> HIV/AIDS continues to spread despite all educational efforts; some of the consequences of the epidemic include: mandatory HIV/AIDS testing, changes in Ghanaian customs and beliefs, and a growing number of orphans and institutions to care for them.

## **Sex-related Knowledge of Street Youth**

John K. Anarfi and Phyllis Antwi (1995) conducted a study in Accra, the capital of Ghana, to examine both the AIDS-related knowledge of the street youth, as well as their sexual behavior and practices. They questioned a total of 250 youth between the ages of 10 and 24. They found that 98 percent of the youth had heard of sexually transmitted diseases, and their level of knowledge about STDs was fairly high, considering the fact that they had little to no formal sexual education. Without being prompted, over half of the youth mentioned discharge and pain in the lower abdomen as symptoms of STDs. However, some youth displayed misconceptions about the transmission of sexually transmitted diseases, especially HIV. Although they were able to identify medical causes, such as sexual contact, 48 percent of females and 34 percent of males identified witchcraft as a cause of transmission. Nineteen percent of females and nine percent of males attributed transmission to God or other supernatural causes, and 47 percent of females and 54 percent of males identified kissing as a possible cause of transmission. Only 34 percent of the sexually-active youth who were interviewed had ever used condoms.<sup>21</sup>

Anarfi and Antwi note that there are a number of misconceptions about what constitutes safe sex in Ghana. One false belief is that a person is immune to transmission if he/she engages

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<sup>20</sup> Teye, 69.

<sup>21</sup> Anarfi and Antwi, 144, 147, 148.



in sexual activity with an HIV-positive person only once and very quickly.<sup>22</sup> Also, if the woman is on top of an HIV-positive man during sex, then she is considered safe from contracting HIV. Prostitutes were formerly known to wear charms around their waists to protect themselves from contracting HIV. Furthermore, a widely accepted notion is that antibiotics taken with strong alcohol can cure HIV, and most of the youth that were interviewed self-medicated themselves this way.<sup>23</sup> When asked if they had changed their sexual behavior after hearing about AIDS, only nine percent said they now practice abstinence, and ten percent started using condoms regularly. My observation is that condoms are not only difficult to find in rural areas of Ghana, but it is also unreasonable to assume that impoverished people will invest in condoms, especially considering the cost in relation to items necessary for survival. Forty-five percent of the youth said they did not have sex until their partner was well-known, 42 percent reduced their number of sexual partners, and a third said they no longer had sex with prostitutes.<sup>24</sup> Although all of these behavioral changes are a positive result of HIV/AIDS education, none are guaranteed to protect one from transmission.

If the youth understand that AIDS is life-threatening and is obtained through sexual contact, then why are they not making dramatic changes in their sexual behavior? The United States Agency for International Development (USAID) launched an educational media campaign about HIV/AIDS. Their study showed that the campaign successfully raised the awareness of the youth, yet the study by Anarfi and Antwi shows that the youth have largely failed to change their behavior in meaningful ways.<sup>25</sup> One explanation for the lack of behavioral change may be

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<sup>22</sup> Yankah, 184.

<sup>23</sup> Ibid, 185.

<sup>24</sup> Anarfi and Antwi, 148.

<sup>25</sup> Anarfi and Antwi, 148.

the dissonance created by increased sexual activity among youth due to Western influence and a cultural reluctance to loosen strict attitudes toward sex.

## **Attitudes toward Sexuality**

Venereal diseases are highly stigmatized in Ghana. One possible explanation for the stigma is the deeply rooted attitude toward sex from the pre-colonial era. Formerly, puberty rites constituted a benchmark in young girls' lives. At these ceremonies, girls were closely scrutinized to determine their virginity; girls were shamed and suffered consequences if they were not virgins at this time.<sup>26</sup> Adults maintained strict social norms for sexual activity, and very little sex was acceptable even after marriage.<sup>27</sup> The social policing of sexuality has diminished since puberty rites have lost significance and are no longer widely practiced as a result of the colonial period and Christian influence.<sup>28</sup> Furthermore, in pre-colonial times, parents played a prominent role in choosing a husband for their daughters. Suitors paid "knocking fees" to parents as a statement of intention to marry their daughters. In present times, after a boy pays a "knocking fee," he may feel entitled to engage in sexual activity with his intended bride. A man may not be able to afford the required brideprice for marriage, so the "knocking fee" gives him sexual access to a female in the meantime. The social norms that restricted sexual activity have been loosened due to urban lifestyles, the influence of Western culture, and the postponement of marriages because of poverty.<sup>29</sup>

According to Anarfi (2003), another contributing factor to the stigmatization of AIDS and other STDs is the fatalistic attitude toward death that some Ghanaians hold. Anarfi writes

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<sup>26</sup> Ibid, 144, 139.

<sup>27</sup> Anarfi, 31.

<sup>28</sup> Anarfi and Antwi, 139.

<sup>29</sup> Anarfi, 32, 31.

that people may feel powerless over the timing of their death due to the notion that timing of death is preordained.<sup>30</sup> For those who have this mindset, the cause of death is irrelevant, because the death itself is inevitable. Furthermore, Ghanaian culture is customarily oral, and people may respond to tragedies with silence in order to avoid evoking painful memories.<sup>31</sup> This notion of the unspeakable creates verbal taboos around topics like STDs. Furthermore, HIV-positive people may revert to attitudes of avoidance or denial because of the association between AIDS and urban promiscuity.<sup>32</sup> Some people identify the supernatural as the cause of transmission.<sup>33</sup> Those who are infected with AIDS are assumed to have committed a sexual sin related to prostitution or moral deviance. AIDS is perceived by some as a punishment from God, and therefore, good people are immune.<sup>34</sup> Furthermore, deadly diseases are often associated with the exotic or the “different other.” A common misperception is that one can visibly determine whether or not a person has AIDS, and AIDS is often associated with those who are visibly different. Therefore, one is practicing safe sex if he or she is sleeping with familiar people, or at least people who look familiar. Because emaciation is linked with AIDS, a healthy appearance is associated with sexual health.<sup>35</sup> Conveniently, Ghanaian beauty standards favor curvy women to thin women, allowing men to have the illusion that they are practicing safe sexual behavior when sleeping with the most beautiful women. Due to the idea that only promiscuous or immoral people carry HIV, it is unpopular to request condom use for fear of the implications.<sup>36</sup> Doctors sometimes contribute to the silence around HIV by avoiding diagnosing their patients as HIV-positive, treating the symptoms without naming the disease. In the 1980s, especially, doctors

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<sup>30</sup> Anarfi 33, 30.

<sup>31</sup> Yankah, 181.

<sup>32</sup> Anarfi, 30.

<sup>33</sup> Yankah, 185.

<sup>34</sup> Anarfi, 28.

<sup>35</sup> Yankah, 183-4.

<sup>36</sup> Anarfi, 29.

may have diagnosed their patients with other diseases, like cholera or tuberculosis, because these illnesses did not have a stigma attached. Therefore, people who are unaware of their HIV-positive status may unknowingly infect their sexual partners.<sup>37</sup> The stigma of AIDS remains, because it is encouraged by some Ghanaian attitudes and sometimes even by medical professionals.

## **Women's Role in the Spread of HIV/AIDS**

Lack of female empowerment also provides an explanation for the continued spread of HIV/AIDS in Ghana. Luginaah, Yiridoe, and Taabazuing (2005) write, "...persistent gender inequities, socio-cultural norms, together with the position of some churches on issues such as condom use, continue to make it difficult for women to negotiate safer sex practices."<sup>38</sup> Not only are women biologically more vulnerable to HIV contraction, they may also be largely dependent on their male partners for economic survival.<sup>39</sup> According to scholars like Teye and Green, the patriarchal norms in the kinship system currently keep women economically dependent on men, reducing women's ability to negotiate condom use and allowing men to have power over women's sexual behavior.<sup>40</sup> Patriarchal power structures certainly operate in Ghana; however, the research of scholars like Claire Robertson illustrates how Ghanaian women are also important contributors to the household income, dominating the market place and local farms.<sup>41</sup> Regardless, patriarchal norms dictate that a wife should be available to her husband for sex at all

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<sup>37</sup> Yankah, 196; Wallman, Sandra. 1996. *Kampala Women Getting By: Wellbeing in the Time of Aids*. London: James Currey.

<sup>38</sup> Luginaah, Yiridoe, and Taabazuing 1698.

<sup>39</sup> Oppong and Agyei-Mensah, 78; Teye, 66.

<sup>40</sup> Teye, 67; Green, December. 1999. *Gender Violence in Africa: African Women's Responses*. New York: St. Martin's Press.

<sup>41</sup> Robertson, Claire. 1995. "Women in the Urban Economy." *African Women South of the Sahara*. Ed. Margaret Jean Hay and Sharon Stichter. New York: Longman Publishing.

times. Married couples may have an especially difficult time discussing HIV and AIDS, because the implication of these discussions is that someone has been unfaithful. Some Ghanaians practice unprotected sex as a sign of trust and commitment; however, extramarital affairs are not uncommon, especially by men. Even if a woman's husband has other sexual partners, she may lack the power to demand condom use.<sup>42</sup> Despite the fact that male extramarital affairs are to blame for spreading the disease in much of Africa, women continue to be held responsible for the spread of HIV.<sup>43</sup> Historically, Ghanaian women have been blamed as the sole source of venereal disease; in colonial Asante, this social stigma and association resulted in the arrests of single women.<sup>44</sup> Some women stay with their husbands even if they are engaging in extramarital affairs, because divorce would make them economically and socially vulnerable, and Ghanaian culture highly values marriage and reproduction.<sup>45</sup>

Ghana has high fertility figures, because parents living in rural areas may be dependent on children for economic support. Furthermore, in patriarchal societies that emphasize the significance of lineage, it is important for a woman to produce at least one male heir for her husband or brother (in the case of the matrilineal Akan), and she may continue to have children until she has a son. This desire for more children hinders condom use: "Since condom use prevents conception it is axiomatic that people who want additional children with their current partners may not be able to use condoms for HIV prevention."<sup>46</sup> Also, female infertility can result in divorce, so married women might have unprotected sex even though they are risking HIV infection in hopes of getting pregnant.<sup>47</sup> As Teye (2005) writes, "...people are aware that

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<sup>42</sup> Anarfi, 29.

<sup>43</sup> Teye, 71.

<sup>44</sup> Allman, Jean. 2005. "Rounding Up Spinsters: Gender Chaos & Unmarried Women in Colonial Asante." *Gender in Africa*. Ed. Andrea Cornwall. Bloomington: Indiana University Press.

<sup>45</sup> Anarfi, 34.

<sup>46</sup> Teye, 68.

<sup>47</sup> Ibid, 70.

certain actions may lead to a loss but it is the perceived magnitude of the loss that matters.”<sup>48</sup>

Therefore, if people do not feel that they are at risk of contracting HIV, and they value their marriage and children, then they are not likely to practice safe sex. The societal values of marriage and fertility constrain condom use.<sup>49</sup>

Females are also socially vulnerable because of inferior education. Parents tend to prioritize their sons’ educations over their daughters’, so if the parents can only afford school fees for one child, they will likely send their son before their daughter.<sup>50</sup> Female children may also be forced to drop out of school in order to take care of parents who are infected with HIV/AIDS.<sup>51</sup> Uneducated females are more likely to be impoverished, and they may be economically motivated to engage in prostitution.<sup>52</sup> Many sex workers make more money than those engaged in market professions, so young girls may be inspired to enter the trade at a young age. Female prostitutes are subject to the same gendered power dynamic as married women; they are dependent on their male clients’ contraception preferences. Women who do not formally engage in prostitution may still exchange sex for financial assistance from older men. Sex is used as a survival strategy by both married and unmarried women. Extreme poverty and dependence make women more vulnerable to HIV/AIDS.<sup>53</sup>

## The Church’s Role

Religious affiliation also affects how one will respond to the threat of HIV/AIDS. Oppong and Agyei-Mensah write that HIV/AIDS rates are lower in the northern part of Ghana where Islam is

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<sup>48</sup> Ibid 66.

<sup>49</sup> Teye, 70.

<sup>50</sup> Anarfi, 39.

<sup>51</sup> Ansah-Koi, 557; Crentsil, 58.

<sup>52</sup> Anarfi, 32.

<sup>53</sup> Teye, 66, 70.

practiced due to the religion's strong discouragement of promiscuity and the practice of male circumcision. Circumcision has been proven effective in the prevention of HIV transmission because it is the removal of an increased number of HIV receptor cells in the mucosa of the foreskin.<sup>54</sup> Oppong and Agyei-Mensah say that, although Christianity encourages monogamy, the Christian rhetoric of forgiveness leaves space for sexual promiscuity.<sup>55</sup> Islam also includes doctrines regarding forgiveness, so this claim might reflect some author bias.

Faith-based organizations, because of their guiding role in their members' lives, seem to be appropriate tools for education about HIV/AIDS.<sup>56</sup> In sub-Saharan Africa, religious organizations are becoming increasingly involved in community-based prevention and education programs. Congregations provide a support system for those affected by HIV/AIDS, sometimes even assisting such families with income generation strategies.<sup>57</sup> Furthermore, Christian churches involve the use of 'healing' and 'salvation', which may appeal to the needs of an impoverished population affected by HIV/AIDS.<sup>58</sup> However, one must be cautious when making assumptions about the complete benevolence of Christian churches, because HIV/AIDS is regarded as a moral sin, prone to judgment and condemnation.

Currently, some Protestant, Pentecostal, and Evangelical churches in Ghana are mandating HIV/AIDS testing among members of their congregations; the testing is especially forced upon engaged couples. The Senior Pastor may discuss the implications of a couple's test results as part of pre-marital counseling. Although test results should be confidential, this method allows potential spouses and their families to gain access to test results. Mandatory HIV

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<sup>54</sup> Quinn, Thomas C. 2007. "Circumcision and HIV Transmission." *Current Opinion in Infectious Diseases*. 20.1, 33-38.

<sup>55</sup> Oppong and Agyei-Mensah, 80.

<sup>56</sup> Luginaah, Yiridoe, and Taabazuing, 1691.

<sup>57</sup> Bazant, Eva S. and Marc Boulay. 2007. "Factors Associated with Religious Congregation Members' Support to People Living with HIV/AIDS in Kumasi, Ghana." *AIDS and Behavior*. 11: 936-45.

<sup>58</sup> Takyi, 1222.

testing is largely viewed as a violation of human rights: “The *International Covenant on Civil and Political Rights* states that no one ‘shall be subjected to arbitrary or unlawful interference with his privacy.’” Furthermore, the influence and power that some churches have over their members’ lives indirectly coerces members to get tested. Some scholars fear that mandatory HIV testing will only push HIV/AIDS underground, causing the disease to be further stigmatized and the infected members of the community to be discriminated against.<sup>59</sup> In addition, most churches do not promote condom use, so HIV/AIDS testing is more of a reactive measure rather than a preventative one.

## Cultural Consequences

HIV/AIDS also has serious consequences for Ghanaian culture. The Akan people, who constitute 44 percent of Ghana’s population, have lost many potential ancestors to the disease. In Akan culture, “good” deaths create ancestors; an ancestor is someone who lived an honorable life and died at age 70 or older. HIV/AIDS results in many “bad,” or early, deaths; the spirits of the young people who died from the stigmatized disease are thought to roam about causing mischief. AIDS deaths fail to produce ancestors, thereby challenging Ghanaian culture and cosmology. Deaths by AIDS are not celebrated with elaborate funerals in the way that other Ghanaian deaths are celebrated. Most Akan funerals provide opportunities for economic activities; the grieving family is sometimes given small monetary contributions as an expression of sympathy and solidarity. Surviving family members of AIDS victims are not given this opportunity for financial assistance or psychosocial support. Furthermore, when people in the generation of parents and laborers die, the elderly are left to care for the very young,

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<sup>59</sup> Luginaah, Yiridoe, and Taabazuing, 1690-7.



contradicting the custom of the elderly gaining more power and fewer duties as they age. The death of mothers challenges the social values of fertility and procreation. Sex was customarily viewed as an act performed for the purpose of producing a strong child, who would eventually become a productive member of society, but HIV causes many children to die shortly after birth. Sex is increasingly viewed disapprovingly as solely an act of pleasure, and HIV further condemns sex, transforming it from a powerful, life-giving act to one threatening death. Crentsil (2007) writes, “In the context of Akan matriliney, infection during childbirth means the mother’s blood which symbolizes the lineage and should protect both mother and child rather ensures their death”.<sup>60</sup> Therefore, the life-giving power of sex and the power of female fertility have been diminished by the outbreak of HIV/AIDS.<sup>61</sup>

## **AIDS Orphans**

The HIV/AIDS epidemic has also caused a dramatic increase in the number of AIDS orphans. Adults of childbearing age are most affected by HIV/AIDS. As these adults are slowly debilitated by the disease, they have few resources to leave behind for the children who are orphaned. As of 2004, 12 million children living in sub-Saharan Africa had lost one or both parents to AIDS. 132,000 of those children are living in Ghana.<sup>62</sup> Historically, the strong kinship system in Ghana allowed for orphans to be absorbed into their aunts’ and uncles’ families. Today, however, children are losing parents, and increased urbanization has divided families and reduced a sense of kinship responsibility, so many times, grandparents are left with

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<sup>60</sup> Crentsil 59.

<sup>61</sup> Ibid, 55-61.

<sup>62</sup> Ansah-Koi, 555. 556.

the responsibility of caring for orphans.<sup>63</sup> This system of kinship fostering is breaking down in Ghana not only because of increased urbanization, but also because of the overwhelming number of orphans and extreme poverty. Ansah-Koi (2006) writes, “When people struggle to meet the basic needs of their own children, it is very difficult for them to take upon themselves the additional burden of caring for other people’s children.”<sup>64</sup> Family members may not wish to foster orphans due to the financial strain of another child or possibly because HIV/AIDS is a stigmatizing disease. Informal care systems are no longer adequate for the many orphans. Since the AIDS outbreak, many more orphanages have been established, especially in southern Ghana. Between the growing number of orphans and the breakdown of the informal fostering system, there seems to be a greater need for governmental intervention to develop private fostering systems and acceptable institutional care.<sup>65</sup> Currently, there is a lack of resources to support AIDS orphans in Ghana.

## **Implications for this Study and Methodology**

The study conducted by John K. Anarfi and Phyllis Antwi on sexual practices and knowledge of street youth indicates that Ghanaian society is currently experiencing a transition. The authors of this study state that the older generation holds onto strict values about appropriate sexual behavior; meanwhile the youth engage in sexual experimentation.<sup>66</sup> Therefore, communication between generations about sexual activity is lacking. These authors indicate that sexual education is largely nonexistent in Ghanaian schools, so most of the information that the youth

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<sup>63</sup> Schoofs, Mark. 1999. “Aids: The Agony of Africa.” *Village Voice*. 1-8.

<sup>64</sup> Ansah-Koi 557.

<sup>65</sup> Ibid, 555-562, Crentsil, 58.

<sup>66</sup> Anarfi, 35.

receives about sex comes from Western media or their peers.<sup>67</sup> Poverty also hinders the movement to a more sexually healthy society, because health services, clinics, and social workers are scarce, and there are not enough health education materials for the youth and the illiterate.<sup>68</sup> Furthermore, the increasing number of orphans challenges the already strained communication between generations regarding sex. While volunteering at an orphanage near Cape Coast in July of 2008, I asked the orphanage director whether the caregivers tell the children that their parents died due to AIDS. The orphanage director responded that this information is not appropriate for children and is therefore kept private, and in some cases the children were not told that their parents had even died. These discussions were avoided as the children were shuffled along to healthy family members and then to the orphanage as their parents became too ill to care for them.

This information confirmed my assumptions about the lack of transgenerational communication regarding sex and raised questions in my mind: What information regarding HIV/AIDS is considered appropriate for children in Ghanaian culture? What cultural taboos surround AIDS, and how do they affect children who are orphaned due to the disease? What information do the caregivers at orphanages have about HIV/AIDS, and how accurate is it? Because the number of AIDS orphans is rising in Ghana and in other African countries, I felt that these questions were in need of urgent answers and action.

I designed an independent undergraduate research project that would allow me to seek the answers to my questions. I traveled to Ghana on July 1, 2009 in order to conduct a six-week independent research project under the guidance of Dr. Walter Rucker from the Department of African American and African Studies at the Ohio State University. I visited three orphanages

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<sup>67</sup> Anarfi and Antwi, 141.

<sup>68</sup> Anarfi, 29.

throughout the Central and Eastern regions of Ghana in order to interview orphans and their caregivers about the nature of their experiences related to HIV and how the disease-related stigma affects the way the AIDS orphans are treated. I was interested in the children's insights and the caregivers' opinions about what AIDS-related information is appropriate for children. I was also interested in the accuracy of the information that the caregivers supply to the children.

The orphanages that I selected for this study include: The Children's Home of Hope in Asebu, where I volunteered the previous summer, Countrywide Children's Welfare Home in Awutu Bawjiase, which was recommended to me by an Ohio State graduate student, and Nectar Home Orphanage in Odumase – Krobo, which was recommended to me by a Ghanaian friend. I interviewed at least one caregiver from each orphanage and a total of twenty-two children ages ten and over. The orphanages vary in size from 20 children to 150 children, so the number of orphans that I interviewed from each orphanage was relative to the orphanage's size.

I employed Elvis Morris Donkoh, a Ghanaian man who works extensively with AIDS patients and AIDS orphans, as my translator so that the interviews could be conducted in the Akan dialects, which are native to the Central and Eastern regions. Mr. Donkoh founded "Alliance for Youth Development," an NGO that benefits women and children living with HIV/AIDS in the Cape Coast area, and he is the director of the Children's Home of Hope. I depended on Mr. Donkoh not only as a translator, but also as a cultural liaison. I felt that his presence mitigated the intimidation the interviewees might feel from being a research subject for a foreigner, especially one with obvious economic and social privileges. He also advised me on how to approach this topic in a culturally appropriate manner. At the Children's Home of Hope, however, I asked a social work intern to serve as the translator in order to avoid biases Mr.

Donkoh might have when translating for children who are a part of his organization, creating the slight possibility of varying interpretations of the children's responses.

All of the interviews were digitally recorded and then transferred into password-protected encrypted files. Names of the children are omitted from this research. The only identifiable information that is referenced is the participants' age and gender, which is necessary for adequate interpretation of the research results. All of the interviews were conducted in secluded spaces so that no caregivers would be able to overhear. Furthermore, participants were informed that the interviews were confidential and to be used for academic purposes only. All were assured that they could refuse to answer a question or that they could leave the interview at any time. The caregivers, with whom I conducted interviews, were asked to sign consent forms, and they were given ten Ghana cedis, or enough money to buy two meals, in order to thank them for their participation. In addition, I made a donation of rice to each orphanage.

My intention was to select the children randomly at each orphanage, affirming with caregivers that each child was ten or older. However, I was unable to randomly select interviewees at Countryside Children's Home or Nectar Home, because the administrators assigned children for me to interview. I felt that in order to be respectful of the orphanages' owners and staff, I needed to accept their guidelines and recommendations. Unfortunately, however, this led to an unequal proportion of male and female respondents.

When constructing interview questions, I assumed that HIV/AIDS education in Ghana is limited and that children living in institutions are disadvantaged in comparison with children in surrounding communities. I was prepared to find that communication about HIV/AIDS between caregivers and orphans is severely limited, and discussions about sex are largely avoided. However, this research complicates these assumptions, illustrating how education about

HIV/AIDS and stigmatization of the disease can occur simultaneously. Furthermore, current policy built on the assumption that institutional care is inferior to home-based care may be overlooking the nuances of this issue.

Chapter One of this thesis discusses the results of the twelve interviews conducted at Countryside Children's Welfare Home. The responses received from ten children regard their quality of life at the home, their knowledge about HIV/AIDS, their emotional attachments to the disease, and with whom they discuss HIV/AIDS. The chapter also provides a summary of interviews with two caregivers about what information they feel is appropriate to share with children about HIV/AIDS, as well as their personal knowledge of the disease.

Chapter Two then provides a summary of the nine interviews conducted with children and the interview with a caregiver at Nectar Home. The home's mission to educate about HIV/AIDS is examined by measuring its effectiveness in reducing the AIDS stigma. Children's Home of Hope interviews with three children and one caregiver are discussed in Chapter Three. The newly established, smaller children's home is compared to larger homes that have been established for about twenty years.

Finally, the results of all interviews are summarized in the Conclusion, which provides an explanation of how this particular project upsets some initial assumptions gathered from previous research. The particular interest of this research project is then expanded on by discussing the dangers of the Care Reform Initiative of 2006 and its effects on orphans and vulnerable children in Ghana. The reform, which is believed to be in the children's best interest, forces institutionalized children back into local communities, thereby limiting access to resources that are provided by orphanages and children's homes.

# Chapter One: Countryside Children's Welfare Home

In order to find the Countryside Children's Welfare Home, located in the Central Region of Ghana, one must follow a variety of rusted, old signs through town. Even the driver, who had visited the home on numerous occasions, made a couple of wrong turns before finding the dusty little road that veers away from the community, opening into a beautiful plot of land. The home consists of about ten brightly painted buildings, buzzing with the energy of a hundred fifty children of all ages. The orphanage is complete with a dining hall, an office for the administrators, a school, farming plots where the children help to grow vegetables, a fishing pond, and designated areas where pigs and chickens are raised. Upon my arrival, I was greeted by Mr. Osei, the manager of the home, who reviewed my research plan with me before taking me to get the blessing of the father and mother of the home. The home was founded by Madam Emma Boafo Yeboah in 1983 when she was caring for a dozen needy children on rented premises. Since then, she and the father of the home, Captain Joe Yeboah, have expanded when possible by slowly buying additional plots of land and building living quarters to house more children.

The home's mission is "to meet the needs of needy children, [and] make them assets as God provides the resources through mankind." Rooted strongly in a Biblical foundation, the home seeks to "promote the development of the children in body, mind and spirit." Complete with a Preparatory School, Countryside offers affordable tuition to children in the surrounding community, while sponsoring its residents' education. Its vision is to build an infirmary and

clinic for the treatment and prevention of common illnesses as well as for community outreach and education regarding HIV/AIDS.<sup>68</sup>

I was seated in the home of the father and mother, entirely unsure of what to expect. Mr. Osei guided the father of the home into the room. Mr. Yeboah appeared to be elderly and in poor health, stout with snow-white hair, and his milky eyes and walking cane indicated his blindness. Mrs. Yeboah was kind and welcoming and sat quietly next to her husband, whose dignified presence and direct gaze humbled me. I knew that no amount of planning or paperwork could actually prepare me to conduct research on the lives of marginalized children, and this awareness was heightened as Mr. Yeboah spoke to me about his mission to do God's work. I sensed his lack of trust, as if I were yet another foreigner who dropped by to behave as if I were the expert on his life's work. I reassured him that I was there purely for the pursuit of knowledge and that I was honored to be welcomed into his beautiful home. Because orphanages are currently under great scrutiny in Ghana, it was important for me to assure Mr. Yeboah, as well as the participants, that the interview responses were anonymous and to be used for academic purposes only. He gave his blessing, and I was told to wait in the courtyard while Mr. Osei selected children to be interviewed.

The courtyard was bustling with three to five-year-olds, whose interest we piqued as the newest strangers. My first few interviews with children were quite difficult because I was nervous, and the little ones insisted on climbing into my lap. However, I was reassured by the strength and confidence of the young people I interviewed, who did not flinch when telling me about becoming orphaned and their journeys to the children's home. I began by asking them their names, ages, and how long they had resided in the orphanage. Most of the children had lived at the home between five and eight years, arriving between the ages of four and twelve, but

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<sup>68</sup> Countryside Children's Welfare Home, 2009, Visitors' Pamphlet.



a few were too young to recall an exact age at arrival. The children that I interviewed fell between the ages ten and eighteen, and eight of the ten children were male. The average age of the children I interviewed was 13.8; the average age of the boys was 13.4, and the average age of the girls was 15.5. Some of the interviews were conducted in English, while others were conducted in Twi or Fante with the help of a translator. I estimated their levels of education by their proficiency in English. Those who attended private school or were enrolled in advanced classes benefited from a higher degree of education, which was reflected both in their mastery of English and their knowledge of health-related matters. Forty percent of the interviewees were proficient in English; one quarter of the boys and both of the girls were interviewed in English, and the average age of the English-speaking children was 16.3.

## **Quality of Life**

I began by asking some basic questions about the children's lives at the home with the intention of easing them into the interviews and getting more background knowledge before jumping into questions about HIV. I asked, "What was it like for you to come to Countryside?" I fully expected that the children would reflect on the difficulties of leaving their communities and their families, especially if their parents' deaths had forced them to move to the children's home. I was immediately made to face my naiveté. Five of the boys said they were happy to come to the home; meanwhile, three were too young at the time of their arrival to remember, and both girls expressed neutral feelings. An eighteen-year-old boy, "Joseph," said, "I was so glad that my uncle brought me here.... I feel at home." A sixteen-year-old boy, "Thomas," spoke about himself and his brothers, who all live at the home: "We are doing well. We are going to school. Everything is here for us." Several boys simply said that they were happy to come to the

orphanage. Neither girl expressed any negative feelings about coming to the home; rather they implied that it was a necessary move that was not particularly difficult for either of them.

I then asked, “Is your life at Countryside different from the lives of the children in the surrounding community?” Every child answered that their lives were in one way or another better than the lives of the children in the surrounding community. They cited reasons such as regular meals, access to education, moral guidance, safety, comfort, and care. Joseph responded, “Everything is here for us. People in the town don’t normally eat. I get food three times a day: morning, afternoon, evening. I go to school. I take my book and learn. Go to the library. Go play table tennis.” Thomas explained the importance of a religious upbringing: “When you go to town you see some of the boys there are doing unnecessary things. But here they will train, teach you what is right, what is good. We read the Bible, church, we do morning devotion every day, we do church service afternoon and evening. Here they are teaching us the right way to go.” This response shows that the home’s religious emphasis has been impressed upon its residents. A thirteen-year-old girl, “Sarah,” spoke of her life before coming to Countryside: “Before I lived here I wasn’t at any school, and I lived in one room, and sometimes I don’t even eat. I walk on the streets when I am small. I am in grade six. And I have a lot of relatives, and many of them have future. I also want to be someone in the future.” The importance of being cared for is further explained by a ten-year-old boy, “Mark”: “Being here is good for me, because when I go to the community, I don’t have anyone to take care of me.” This particular interview question was developed with the assumption that the biggest difference between the children at Countryside and the children in the surrounding community was that these children were orphans. When one has struggled to survive daily, a home that provides education, love, and three meals a day is certainly a better alternative to living in poverty. Many of the children

were brought to the home by aunts, uncles, and grandparents. Their relationships with their parents may have been strained due to their parents' illness, or perhaps they were forced to behave as adults at an early age in order to fend for themselves and their families. The institutional environment provides for the children's basic needs, allowing them to dream about their futures instead of worrying about where they will get their next meals. The participants displayed mature, positive outlooks, indicating the nurturing environment at the home.

I then asked whether the children had friends at the home and whether or not they felt supported by their friends. The majority of the children explained that they not only had friends in the home, but a family. I then asked all of the children how they felt about their futures and what they wanted to do in the future. Every child named a career immediately. The career choices included three aspiring pilots, a lawyer, an engineer, an actress, a doctor, two businesspeople, and a soccer player. More importantly, I asked the children if they felt they had the resources to achieve their goals. Every child said yes. These introductory questions provide a foundation for the research, indicating the children's attitudes about life in the orphanage and their futures, as well as their relationships with others in their community. Speaking in such positive terms generally seemed to relax the children. Beginning an interview with a question about HIV would be very intimidating and would give no context whatsoever for the children's responses. Now I had a little bit of background information and rapport with the participants.

## **HIV/AIDS Knowledge**

At this point in the interviews I transitioned to asking questions regarding HIV/AIDS. Nervous that many of these children had had intimate life experiences with the virus, I tentatively asked, "Have you heard of HIV?" Every child at every orphanage had heard of HIV. I then asked, "In

your opinion, what is it?” Four of the children identified HIV as a “sickness,” and two specified that it has no cure. Two of the participants identified HIV as a deadly disease, and one interviewee indicated that HIV is a deadly virus without a cure. Thomas and an eighteen-year-old female, “Martha,” responded that HIV is Human Immunodeficiency Virus. Thomas said, “HIV is a disease. It is Human Immunodeficiency Virus. When you sleep with infected person, a person who is having HIV, you have sexual intercourse with the person, it will also come to you.” Lastly, a thirteen-year-old male indicated a partial misconception, explaining that a person can get HIV by eating with an infected person or by having sex with a stranger. His statement invokes the widely accepted idea that safe sex is sex with a familiar person, and unsafe sex is with the different other.

Several of the interviewees defined HIV by its means of transmission, which led me to my next question: How do people get HIV? Five of the participants indicated sex as a means of transmission, but some were more specific than others. Thomas was the only interviewee who specified that having sex *with an infected person* can lead to transmission. Several of the others indicated that sex with strangers or sex in general can cause transmission. Joseph explained, “People have sex with their partner and sex maybe with another and they have a lot of sex. So if you want to have sex with someone who is not your partner, use condom. HIV is a virus... deadly with no cure. If you don’t want to get it, then abstain from sex.” He is sending two messages regarding sexual health: use a condom when having sex with a stranger and abstain from sex. Perhaps this is the result of a variety of educational messages regarding sexual health. Sarah identified three possible means of transmission: blood transfusions, sex, and sharing blades or scissors. Sharing razor blades came up frequently at all of the orphanages as a possible means of transmission. Razor blades are used to shave children’s heads, as well as to trim fingernails

and toenails. Three of the children I interviewed at Countryside mentioned sharing blades in their responses. Two of the interviewees incorrectly identified causes of transmission. One fifteen-year-old boy, “Joshua,” said that people get HIV through the air, but in response to how people can protect themselves from HIV, he identified condoms. Although he may not understand the mechanics of contracting a sexually transmitted disease, he has received the message that condoms protect people from HIV/AIDS. A thirteen-year-old boy said that one can get HIV by eating with an infected person. Mark and the eleven-year-old male were not able to identify any causes of transmission.

Although seven of the participants were able to identify at least a partial cause of transmission, fewer were able to answer the question: how do people protect themselves from HIV? Three of the older children (ages eighteen, eighteen, and fifteen) identified condoms as a way to protect one’s self from HIV, and Martha, the eighteen-year-old female also mentioned abstinence. Thomas and Sarah also identified abstinence, and Thomas specified abstaining from sex *with infected people*. They also instructed that one should avoid sharing razor blades, and again Thomas specified sharing blades *with HIV-positive people*. Sarah added that one should avoid blood transfusions. Finally, one twelve-year-old male said that one should clean around after mentioning razor blades as a cause of transmission, and the other twelve-year-old boy responded that one can protect one’s self from HIV by going to the hospital. Three males, ages ten, eleven, and thirteen, did not have a response to the question.

I then asked the interviewees, “How did you learn what HIV is and how people can protect themselves?” Four participants mentioned various groups of people who had visited the orphanage in the past to give informational presentations about HIV. One mentioned people from Accra, Ghana’s capital city; meanwhile, another said people came from the town, and one

mentioned a group of white people. Four of the interviewees had learned about HIV in science class at school. Thomas said, “We have a health clinic there. So they also invite us, our school. They invite us to go, and they also teach us about it.” Most of the older children (ages twelve to eighteen) had learned about HIV at school or from groups who visited the orphanage. The younger children (ages thirteen and under) identified other sources of their information. Mark, who identified HIV as a sickness with no cure but did not know how one gets HIV or how one can protect one’s self, said he learned the information from television. A twelve-year-old male, who knew that one can get HIV, which he identified as a sickness that kills people, by sharing razor blades, said that he received the information from the orphanage manager. Finally, a thirteen-year-old boy, who could not define HIV but who named eating with an infected person and sex with a stranger as causes of transmission, was the only participant who identified the father and the mother of the household as his sources of information. His misunderstanding of transmission and general lack of knowledge about HIV seemed to confirm the assumption that communication about HIV/AIDS between caregivers and orphans is less than adequate.

## **Emotional Reactions to HIV/AIDS**

It is one thing to examine the children’s factual knowledge about HIV, but I hoped to gain access to the emotional meanings they had attached to the disease by asking, “Are people with HIV different from other people?” and “How should people with HIV be treated?” All but one child were consistent in their answers to these questions. Joseph responded that people with HIV are not different and that “We are all one being, so we can’t separate ourselves from them. Those with HIV, people don’t want to go near them. But they are our brothers and sisters. We don’t get HIV from contact, but we get it from blood.” Thomas agreed that “We are all the same

people” and in response to how HIV-positive people should be treated, he said, “I will come to you, because coming to you doesn’t mean you will also get the disease. I can come and communicate with you. I can make friends with you. But not that we use, let’s say, toothbrush, needles, and those things with you. I will come to you, communicate with you, play with you, be with you.” The fourth student to respond that people with HIV are not different was Martha: “Okay, as we human beings, when we see someone is having the HIV, we treat them like they are not human beings, but I think we should go near them and treat them the right way.” She went on to say that she would not fear sharing a room with someone infected by HIV. An eleven-year-old boy, however, answered that people with HIV are not different and then stated that he would not go near someone with HIV. He would not play with them because it is a dangerous disease; however he would not provoke or harm them in any way.

The remaining six interviewees responded “yes” to the question: “Are people with HIV different from other people?” “So far as someone is living with HIV, I don’t see them to be the same people. I wouldn’t have sex with the person, because we are completely two different people altogether,” said Joshua. He said he would not go near people with HIV or sleep in the same room as they do, and they should be sent to the hospital. Joshua also believed that HIV is contracted through the air, and his interview was translated, indicating that he may be academically behind his fifteen-year-old peers. Four other interviewees echoed the notion that one should not get too close to someone living with HIV. A twelve-year-old boy said he would not shake hands with someone living with HIV and that this person is different from others because “That person was a part of normal human beings, but that person did a bad thing.” Certainly he is alluding to the stigma of moral failure that is attached to HIV. His knowledge of HIV extended to transmission through shared razor blades. Mark, whose knowledge of HIV is

minimal, says that people living with HIV are different because “The person’s blood is not good,” and he will not go near someone living with HIV. “If you have HIV and I don’t have HIV, I can’t compare myself to you,” said one twelve-year-old boy, indicating that he would talk to someone with HIV but he would not get too close. A thirteen-year-old boy echoed the sentiment, saying he would not go near people living with HIV and he would not eat with them either. Sarah gave a more nuanced answer, saying that yes, people with HIV are different because “They will grow thin. They will fall sick,” but that she would go near someone living with HIV, although she would be cautious not to share any sharp instruments with the person.

## **Communication about HIV/AIDS**

Based on my original assumption that communication about HIV/AIDS between adults and children at the orphanages is minimal, I then asked “Who do you talk to about HIV?” and finally, “Can you talk to your caregivers about HIV?” Joseph reported speaking to the mother and father of the home, as well as the secretary, about HIV. The only other children who said they spoke with adults at the orphanage (specifically the administrators) about HIV were the twelve and thirteen-year-old males who had very limited knowledge about HIV, both of whom stated that they would not go near someone with HIV. However, nine out of the ten children interviewed responded “yes” to the question: “Can you talk to your caregivers?” Other parties that the children mentioned when asked, “Who can you talk to about HIV?” included friends, teachers, and visitors. Presumably, these are the same visitors who have come to give presentations in the past. One child specified *white* visitors, indicating that volunteers may have engaged in some type of health education at Countryside in the past. Three males, ages ten, eleven, and thirteen, said they could speak to no one about HIV, although two of these boys answered “yes” when



asked if they can speak with their caregivers. Although the vast majority said they can speak with their caretakers, it seems as though very few of them are actively doing so, and those who claim to be speaking with caregivers have some inaccurate information about HIV/AIDS.

## **Interviews with Caregivers**

I then spoke with two caregivers at Countryside in order to get their perspectives on what information regarding HIV is appropriate for children and whether or not they speak openly to the children about sexually transmitted diseases. I first interviewed “Auntie Margaret,” who had been employed by Countryside for fifteen years at the time. She is specifically in charge of nine children at the home. She told me that before beginning her work as a caregiver, she knew that HIV could be transmitted through sex and by sharing razor blades, and once she was employed, she learned that HIV can also be transmitted through open sores. She was not educated by the management of the home; rather, she learned the additional information from visitors who came to the orphanage. She also said that one can get HIV by kissing someone who is HIV-positive, which is not accurate. When asked if she speaks with the children at the home about HIV, she said that she does not intentionally educate them, but if it comes up in conversation, she speaks with them about it. She said, “It is good to talk to them about HIV, because they are ignorant about the disease, and it will be beneficial to them in the future if they talk about it.” She told me that nothing prevents her from discussing HIV with the children. I then asked what information regarding HIV is appropriate for discussing with children. She responded, “The best thing to talk to them about is sex because that is the main issue. And also, once they are here they don’t really know anything, but as soon as they go outside, they meet their friends, and peer pressure, and I think talking with the kids about sex and sexuality is a good thing.” This

statement directly contradicted the assumption that sexuality is not a topic of conversation between adults and children. Although she said she would not discriminate against a child with HIV, I asked her how the surrounding community feels about people with HIV in order to get a general idea of the community's attitude toward people with HIV. She told me a story about a woman who died of AIDS in the community. No one knew that she was HIV-positive until after her death, at which point they discriminated against her children because they believed the woman had been bad. Although Auntie Margaret was open to people living with HIV, her story led me to believe that her attitude was exceptional, and the community still stigmatizes those living with HIV/AIDS. Finally, she reported that the home does not have any special resources for children living with HIV, and none of the children in the home are HIV-positive. If she were interacting with HIV-positive children on a daily basis, her answers to the interview questions would be more grounded in experience rather than supposition. Her reasoning that a child's HIV status should be kept private seemingly contradicted her simultaneously belief that HIV can be transferred through the act of kissing. If one believes that saliva can transmit HIV, one might also draw the conclusion that sharing eating utensils would be dangerous, creating the need to alert other children if one has HIV. Her lack of exposure to children living with HIV possibly hindered her responses.

I also interviewed "Auntie Esther" at the Countryside Children's Home. She had worked at the home for five years and was responsible for five children. She told me that she did not know any information about HIV before beginning her work as a caregiver. Once employed, she learned about HIV/AIDS from Ghanaians who visited the home to do HIV testing and to give information about HIV. Now she understands that one contracts HIV when his/her blood mixes with the blood of someone who is HIV-positive. Because she cares primarily for very young

children, she does not speak with the children about HIV, but she tries to reinforce the importance of the information when people come to educate the children about HIV/AIDS. She says, “Nothing would prevent me from talking to the kids about HIV. Whatever I would do for my own children, I would do for these kids as well.” When asked what information regarding HIV is most important for children to know, she said they must know not to share sharp instruments, and it is also important to talk to them about how they eat. She did not explain how a child’s diet is important in the prevention of HIV/AIDS. Her attitude toward people with HIV seemed very open; she said that she would not hesitate to be with such a person as long as there was no possibility for blood contact. She also believes that the surrounding community does not discriminate against people living with HIV, but she does not know of any people who have had HIV/AIDS. Finally, she echoed Auntie Margaret’s sentiment that there are no resources at the home to assist children who have been orphaned by HIV or who have HIV themselves, adding that, “We don’t have the knowledge to care for those kids.” Overall, she seemed very open-minded, but she had no personal experience with anyone living with HIV/AIDS. Both of the women’s lack of personal experience with anyone openly living with HIV/AIDS indicated that those in the community who are living with the disease have been silence.

## **Summary of Results**

Overall, assumptions about limited sex education in Ghanaian schools may not be completely accurate based on the number of participants who cited school as a source of their HIV/AIDS information. Surprisingly, a higher percentage of participants mentioned condoms as a means of protecting one’s self from HIV/AIDS at this Christian orphanage than at the remaining two orphanages. The home’s biblical foundation was demonstrated in a couple of interviews, in

which the participants mentioned moral guidance and Bible study as important benefits of the institutional environment. Although some of the participants were congenial to those living with HIV/AIDS, the majority felt that people with HIV/AIDS are different and many indicated that they would not go near a person living with HIV/AIDS. Meanwhile, the housemothers indicated that they were open to conversations about HIV/AIDS but that they did not necessarily initiate them. They were also open to the possibility of caring for HIV-positive children. The children's stigmatizing attitudes toward HIV/AIDS may be forced to change if the home were open to AIDS orphans. Furthermore, the housemothers would be forced to engage in educational conversations about HIV/AIDS. Overall, the quality of life at the home seemed to be very high, and both the caregivers and the residents were receptive to the idea of transgenerational conversations regarding HIV/AIDS.

## Chapter Two: Nectar Home

The second orphanage I visited was called Nectar Home, located in the Eastern Region an hour north of Accra. Founded by Presbyterian minister, Felix A. Anyasor, Nectar Home's purpose is to provide shelter, care, and medical aid for children living with HIV/AIDS, and other orphans and vulnerable children are also welcome. HIV/AIDS rates are some of the highest in Ghana in the local Manya Krobo District; these high rates are attributed to prostitution. Recognizing the consequence of the HIV/AIDS stigma for innocent children, the home works to combat the stigma through education and advocacy. This home was significantly smaller than Countryside, with only one residential building, divided into boys' and girls' sides and one administrative building. The home was set apart from the local community, just as Countryside had been, and it included grassy space for soccer games, a small library, and individual farming plots for the older children. Unlike Countryside, which had been bustling with life and activity, the home was eerily quiet upon our arrival. I watched the older girls cook over the fire outside, while the housemother and an employed caregiver complained to Mr. Donkoh, whom they had worked with in the past, about the current Care Initiative Reforms, which had forced them to significantly downsize their population.

The Reform, instituted in 2006, dictates that Nectar Home must send as many children as possible back into the community, and the children living with HIV were the first to go. The Department of Social Welfare is challenging the notion that institutional living environments are legitimate homes for children, and local families are favored as caregivers. Many of the children who had formerly resided at Nectar Home were forced to drop out of school, and their host families still came to the orphanage, begging for food and supplies to support the extra children.

At the time, the home accommodated only twenty children, and in the past, as many as forty had resided there, including thirty-seven HIV-positive children. Despite the severe downsizing of the home, I was able to interview nine of the residents.

We set up chairs in the lawn, as it was the most private setting. The gender division was more equal than it had been at Countryside, and I interviewed five boys and four girls. The boys were aged ten through fourteen, with an average age of 12.4, and the girls, aged fourteen through eighteen, had an average age of 15.5. Oddly enough, just as both of the girls at Countryside had spoken English extremely well, all of the females at Nectar Home demonstrated proficiency in English. Meanwhile, only one of the males was interviewed in English. Therefore, 56 percent of my interviews at Nectar Home were conducted in English. English proficiency coincides with greater levels of education, often indicating private schooling or upper level classes. Again, I began the interviews by asking how long the children had been at the home and what it was like for them when they first arrived. The interviewees had all lived at the home between two and seven years, arriving between the ages of eight and twelve, although one boy was unsure of his age at arrival.

## **Quality of Life**

Three of the boys, ages twelve, thirteen, and thirteen told me that they happily arrived at the home. One boy said, “I could see this place was good, because they give us food three times a day. They give us some dress to wear.” Meanwhile, a fourteen-year-old male and a fifteen-year-old female explained the transition to the home in neutral terms, saying simply that the transition was not difficult or that it was just different. The remaining three females described the transition as somewhat difficult. The eighteen-year-old, “Charity,” said, “When I came, I was

thinking about how I would not see my grandmommy again.” The fourteen-year-old female, “Ruth,” also described loss in her transition: “When I first came here, I was very sad, because my mother died, and they buried her. After that, I came here. I was not happy because I didn’t know anybody here.” Lastly, one of the fifteen-year-olds, “Grace,” said, “When I came, I never thought I would be happy here.” In general, the Nectar Home residents described a greater variety of emotions and more difficulties in transitioning to the home than the Countryside residents had. Once again, however, the females expressed the least satisfaction with their transitions to the home.

I then asked how their lives compared to the lives of the children living in the surrounding community. The majority of the children said that their lives were better. All of the boys and one of the females said their lives were better at Nectar Home, explaining that there is less suffering and poverty, their needs are met, they are better fed, and they are generally happier at the Home. One thirteen-year-old boy, “John,” explained, “Some of the children in the town, you don’t see them wearing some dresses – they are just passing. Some are dirty, doing nothing.” The ten-year-old boy, “Clement,” further explained the condition of children living in the town: “Those who are in the community don’t get good food to eat. But those who are here can get good food to eat.” The remaining three females interpreted the differences in lifestyles as more complicated. Charity explained,

Here we have time for everything. We go according to [a schedule] and, those in the community, you know, just move about, although some of them are with their parents, who mistreat them for certain things. But, life here is different from life in the community. When I stayed with my grandmommy, sometimes I do what pleases me, you

know, but here... not everything that pleases you you can do.... We have rules here.

Time you should go to bed, time you should be awake, you know, time for everything. Ruth also referred to the schedule at Nectar Home in response to the question: “This place, we don’t go out in the evening, because the peoples outside, they can move about. They can roam about, and they can sleep the time they like. But here, we are under discipline, so we don’t go about at night.” Finally, Grace mentioned the strict rules that the residents must adhere to, but she also notes that her needs are met at the home: “You can’t go out, but they give you everything you need. They will advise you on everything.” Only the female interviewees seemed to take issue with the rules, discipline, and schedule at the home, possibly because Ghanaian norms dictate that girls contribute more to the upkeep of the home while boys have the freedom to enjoy recreational activities. Furthermore, the girls were generally older than the male interviewees and might have desired more freedom in their adolescence.

I proceeded to ask if children had friends at the orphanage and whether or not they felt supported by their friends. All of the interviewees agreed that they had a support network, and five said that the community felt like a family. When asked about the future, every child had a career in mind, and all but Clement said they felt as though they had the resources to pursue their goals. The careers they listed included: two teachers, two nurses, two doctors, two bank managers, and a journalist.

## **HIV/AIDS Knowledge**

I then transitioned and asked the interviewees if they had heard of HIV. All nine of the interviewees responded that they had heard of the virus. When asked to define HIV, two identified it as a sickness, one as a disease, three as a virus, one as malnutrition, and two did not



define HIV, but rather gave examples of how it is transmitted. One of the interviewees was able to define HIV as Human Immunodeficiency Virus, explaining that it is a deadly virus. I then asked the participants to explain how HIV is transmitted. Seven of the interviewees named razor blade-sharing as a means of transmission, and two specified sharing blades with a person who is HIV-positive. Charity and Grace mentioned unprotected sex, and John named sex more broadly; meanwhile, Ruth said one can get HIV by having an affair with a boy, and Clement mentioned having an affair with someone else's wife. Ruth said, "Our teacher told me that if you sleep with a boy, if you have an affair with a boy, you have HIV." This statement indicates that her sex-education has been limited to abstinence-only approaches. John's reply also indicated that he believed all sex was equally dangerous. I asked, "How do people get HIV?" and he responded, "You have sex with someone." Clement defined HIV as "If you don't get good food to eat, you will grow lean." I then asked how people get HIV, and he responded, "If you have a wife, and you go after someone's wife, you will get HIV/AIDS." This statement invokes the idea that HIV/AIDS is a punishment for social deviance. When asked how people can protect themselves from HIV/AIDS, he said, "If your wife tells you something, you have to listen to your wife to prevent HIV." Clearly, the importance of being faithful to one's partner in order to prevent HIV has been somehow impressed upon him. Finally, two of the girls also listed blood transfusions as a means of transmission, and one mentioned mother-to-child transmission. Charity's response was particularly thorough: "It is a virus that has been transmitted through sex – through unprotected sex, or through the use of razor blades, or blood transfusion, or some children get it if your mother has it." The least accurate response came from a twelve-year-old male, "John," who answered that people are vulnerable to transmission when they are lean. At Countryside Children's Home, some of the children did not have any idea how HIV transmission occurs, but

at Nectar Home, every child had a response, almost all of which were at least partially accurate. The children at Nectar Home also invoke sex more broadly as a means of transmission, implying that abstinence is the primary means of protection.

When I asked the interviewees how people can protect themselves from HIV transmission, six of the respondents answered that people should not share razor blades. Only Charity mentioned condoms as a means of protection. The other two girls who mentioned sex gave clear abstinence-only messages. Ruth stated explicitly, “People can protect themselves by avoiding sex.” Meanwhile, Grace stated, “You must wait.... You must abstain from sex.” Two of the girls also mentioned testing the blood before performing a blood transfusion as a method of HIV prevention. Charity, the oldest female and most informed participant, who mentioned condoms, avoiding shared blades, and testing blood before transfusions, stated that there is no way to protect a child from getting HIV if the mother has it. Although this is not entirely true, one must have access to adequate healthcare in order to prevent transmission. One of the fifteen-year-old females also revealed a misconception. After saying that one contracts HIV by sharing blades, she answered that in order to prevent HIV transmission, people should not share spoons. John, who told me that one contracts HIV when one is lean, answered that in order to prevent transmission, one should go to the doctor. And finally, Clement said one should listen to his wife in order to protect himself.

When asked where the interviewees got their information about HIV/AIDS, four said they had learned at school and six said they had learned at the orphanage; four explicitly mentioned the mother at the orphanage as their source of information. The three children whose only source of information about HIV/AIDS was the housemother all focused on avoiding shared razor blades in order to protect one’s self from transmission, although one of these children was

able to identify HIV as Human Immunodeficiency Virus and briefly mentioned sex as a source of transmission as well. One of the most interesting responses came from Ruth, who said that her school has an HIV club composed of students whose mission is to educate fellow students about HIV/AIDS. Charity told me that her school specifically sponsors programs for HIV/AIDS education. Clement, who emphasized listening to one's wife, identified his source of information as himself, and he was the only interviewee who did not name the school or the home as a resource. Unlike the residents of Countryside, several of the Nectar Home participants indicate that they are actively communicating with caregivers about HIV/AIDS, and many of them are receiving accurate information about HIV/AIDS.

## **Emotional Reactions to HIV/AIDS**

When asked if people with HIV are different, seven of the nine interviewees answered, "yes." Three of these respondents explained that people with HIV are different because they will grow lean. Others explained that they are different because they are diseased, because they can die, or simply because they have HIV. Grace also said that people with HIV are different in the very fact that they have HIV, but she finished her statement with, "We are all the same." John was one of two interviewees who responded "no" to the question, "Are they different?" He said, "They are the same, but there will come a time that they look different. The person will be sick, and if you get the HIV, the person will be smallish." These children's answers reinforce the strong connection between "growing lean" and HIV. The only other child to respond "no" to the question was Clement, whose source of information was himself.

I then asked how people with HIV should be treated, and I received overwhelmingly supportive responses. Six of the interviewees responded in one way or another that one should

be kind to infected people and make them happy. Charity said, “They should be treated equally like any other person. You know, because trying to avoid them wouldn’t solve the problem... It’s just that you be a little conscious of yourself so you don’t get it.” Two of the respondents implied that one should intentionally strive to make HIV-positive people happy; meanwhile others maintained a cautious attitude. John stated, “You can play with the person, but when something cuts the person, you don’t want to use the same sharp edge.” Ruth echoed this sentiment: “You can play with the person, but you don’t have to use the person’s things, like the person’s brush, spoon, and that’s all.” Meanwhile, John gave an uncomplicated response: “Play with the person for the person to be happy.” A thirteen-year-old male also said that one should eat and play with people living with HIV. But when asked if a person could get HIV by eating and playing with an HIV-positive person, he responded, “yes.” Despite this confusion, one can see that the residents of Nectar Home have been receiving messages of acceptance for those living with HIV, even if they may be confused about the actual science of transmission. None of the interviewees gave responses that stigmatized HIV/AIDS. A few answered in neutral terms, saying that one should not take personal items from an HIV-positive person or that people living with HIV should be sent to the hospital. Clement responded simply that he did not know how to treat people living with HIV.

## **Communication about HIV/AIDS**

When asked who the interviewees talk to about HIV, four of nine mentioned the housemother or one of the caregivers as someone they talk to about HIV. Two mentioned teachers in their schools, and two said they talk to visitors about HIV; one specified white visitors. Charity said she talks to anyone who is the same age or older; meanwhile the fifteen-year-old female said she

talks to her junior sisters. John specified one of the older girls in the home as the person he talks to about HIV. Clement did not know who he talks to. I then asked whether or not the interviewees can talk to their caregivers about HIV. Six of nine responded, “yes.” Charity said it is not necessary to talk to them because they already know everything about HIV, so she seems to understand herself to be an educator in the Home. A fourteen-year-old male responded, “no,” saying that he talks to his teachers instead. Finally, Clement responded, “no” without an explanation.

## **Interview with a Caregiver**

I interviewed “Auntie Rose,” who had worked as a caregiver at Nectar Home for two years. Before coming to the home, she knew that HIV is a virus that lives in the blood. Once she was hired she learned more from a local church member who works with HIV organizations and educates Nectar Home staff about the virus. When asked how one gets HIV, she answered, “Some from sexual, and some through blade. If someone uses blade, you don’t have to use the same blade.” She then spoke about bringing one’s own blade to the barbershop and using different blades when trimming children’s fingernails. She said that she advises children about HIV and helps to educate them. I then asked if she counsels children who are affected by HIV because their parents passed away due to AIDS or because they themselves are infected. She responded, “Those who are affected by HIV have gone to the community because of the government program. But once they were here, they were counseling them. The mother also brings them closer to her. She counsels them.”<sup>69</sup> Based on the children’s attitudes and Auntie Rose’s report, it seems as though HIV-positive children were met with acceptance and care at

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<sup>69</sup> The Care Reform Initiative is a policy that began in 2006 and is enforced by the Department of Social Welfare. Its goal is to close institutional homes for children and to place orphans and vulnerable children in foster families.

Nectar Home before moving into the community. I asked Auntie Rose if it is better to talk freely with the children about HIV or to not discuss it, and she said, “It’s good to talk with the children about HIV, because they have to know. If you don’t talk to them, they won’t know. And when we counsel them, then we advise them, we talk with them, then they will know much about it. To know a little is not good.” Because the disease is dangerous, she feels that it is important to remind the children about HIV, and she said that nothing would prevent her from discussing HIV with the children. I asked her what information is appropriate for children in regards to HIV, and she said, “I think the kids are the future generation, the future leaders. If they go out and have sex with someone, they wouldn’t know if the person might have HIV. So, they might have it, and they might die. So it’s always good to talk to them when they are young.” This response implies that she thinks it is appropriate to discuss sexual behavior with children when they are young. However, it is unclear whether she is limiting her messages to abstinence or if she is engaging in more comprehensive sex education. Based on the results of the interviews with children, it seems as though her message regarding sexual behavior is abstinence-only. When asked what it means to her if someone has HIV, she said, “I would comfort such a person who has contracted the virus. It would pain me so much that someone has contracted the virus. And mostly when they get it, they feel like they are not part of the human beings, so all that I would do is bring the person closer to me and tell the person she or he is also part of the humans around.” Auntie Rose seems very open to people with HIV, but her response shows that the stigma of HIV is strong if those who are infected feel somehow less than human. She said that people in the surrounding community are afraid of people living with HIV, although they treat them decently. Her opinion, however, is that people with HIV are not different; all people are the same. When asked if she can distinguish whether or not someone has HIV, she noted that

initially no visual differences are obvious. After some time, however, people may have shingles and grow lean, visually informing her that they are HIV-positive. Finally, I asked if she has any special resources at Nectar Home to help her to care for children affected by HIV. She said that the home has no resources and that they must travel to the hospital for help.

## **Summary of Results**

The children at Nectar Home are more educated than those at Countryside Children's Home about HIV/AIDS. Furthermore, not a single child at Nectar Home said anything stigmatizing about AIDS; meanwhile, more than half of those at Countryside somehow "othered" those living with HIV/AIDS. Based on these results, Nectar Home seems to be successful in achieving its goals of educating its residents about HIV/AIDS and reducing the stigma. However, I received a stronger abstinence-only message from the children at Nectar Home. Since many of the children identified the housemother as their source of information, it seems as though she may be enforcing this message. In general, the females seem to be less satisfied with the quality of life at Nectar Home than their male counterparts or their female peers at Countryside. The majority of the girls feel that the strict rules and structured lifestyle are stifling. The females may also be feeling the tension created by the Care Reform Initiative, because they may be given more household responsibilities when the home can no longer support an adequate staff. At the time, Nectar Home had been more affected by the Care Reform Initiative than Countryside.

## Chapter Three: Children's Home of Hope

The Children's Home of Hope is quite unlike Countryside Children's Welfare Home and Nectar Home. Recently established in 2007, the home is minimally funded by inconsistent private donations. The director of the home, Elvis Morris Donkoh, is a young man who created an organization to care for people living with HIV/AIDS in the Cape Coast area when he was only sixteen. He recognized the need for a home to care for abandoned children as his clients passed away. A community outside of Cape Coast donated an old post office building for the project. After repainting, purchasing bunk beds, and hiring two housemothers, he moved approximately fifteen children into the home. These children all came from surrounding communities, and he perceived their needs to be the greatest of the sixty or so children that he cares for in the Cape Coast area.

The home is located at the top of a hill, surrounded by a dusty school yard that allows just enough space for spontaneous games of football (soccer) with local children. Most of the children attend local government schools, although a few have been given the opportunity to attend a private school in the area because of American and Canadian sponsorships. The children trek a quarter of a mile three or four times a day to fetch water, and they frequently do without electricity or refrigeration. This home is neither as established nor as well-funded as the two previous orphanages. I volunteered at the Children's Home of Hope during the summer of 2008, and my observations about communication between caregivers and children at the home inspired this research.



## Quality of Life

Because the number of children in the home wavers between only twelve and eighteen, and the population of the home tends to be quite young, I interviewed only three children: a ten-year-old boy, “Emmanuel,” a ten-year-old girl, “Ama,” and a fourteen-year-old boy, “Kofi”. All of the interviews were conducted on the peaceful back porch of the home and were translated by a social work intern. The two ten-year-olds were unable to recall the number of years they had spent at the orphanage even though the home had opened only two years prior. When asked about the transition to the home, all of the children responded in neutral terms, saying that the Children’s Home of Hope was “comfortable,” “fine,” and “okay.”

When I asked the children to compare their lives to those in the surrounding community, Emmanuel responded, “They are the same. I am not different from the other ones.” This is the first and only response given by any of the interviewees that declares lifestyles to be the same in the orphanage and outside of it. Because the Children’s Home of Hope is located within the community, and its population is not large enough to constitute an entirely separate entity, the children are socially integrated into the community. They attend school with local children, and they play together in the evenings. The orphanage director invites local children to spend time at the home in order to encourage friendships between members of the local community and the children at the home, who come from surrounding towns. The other two interviewees indicated that their lives are different from those in the town. Ama responded, “My life is different.... Most people ask me for things. At times, I have to give them what I have.... Because I have a lot more than what they have.” A child who often goes hungry feeling that she has much more than her peers demonstrates how impoverished this rural community is. Kofi also comments on benefits of life at the Children’s Home of Hope: “Most children living in Asebu don’t have the

chance to go to school. Some are living in the house, but I have the chance to go to school.”

Many parents in the community cannot afford the necessary uniforms, shoes, or pencils in order to send their children to public school. The three children that I interviewed are sponsored by former volunteers to attend private school.

I then asked if the children have friends who support them at the orphanage, and both of the boys responded affirmatively. Ama, however, said she does not have friends in the home; rather, she has friends at school. This was surprising, considering the fact that this young lady seemed to be a vital asset to the Children’s Home of Hope community, voluntarily acting as a caregiver for the younger children. She may have indicated that she does not have friends at the home because attending private school is a source of pride for her, granting her the freedom to associate with peers instead of being burdened by the responsibility of caring for younger children. Having spent a total of ten weeks at the Children’s Home of Hope, it was clear that the children functioned as a family. The older children provide care, protection, and discipline for the younger children, which is necessary because the two housemothers spend the majority of the day preparing meals and caring for babies.

When asked about their futures, the two ten-year-olds told me that they wanted to be a pilot and a doctor respectively, but neither believed they had the resources to do so. Kofi told me he wanted to be like the founder and owner of the home, whom he called his father. Furthermore, he believes he has the resources to achieve this. It was unclear if being like his father meant that Kofi wished to work with HIV/AIDS patients or if he simply wanted to be an established, well-respected member of the community. The director of the home is a well-known and respected young man with a house and a car, and the young boys especially seem to admire him. Once I began to ask questions about HIV/AIDS, it was clear that Kofi had limited

knowledge and empathy, so I assume that his goals for the future were in regards to social status and economic resources.

## **HIV/AIDS Knowledge**

Although all three children had heard of HIV, their knowledge of the virus was minimal.

Emmanuel said that HIV is “germs that enter into your body, and they kill you, and you die from it.” However, he did not know how people get HIV or how one can be protected from contracting HIV. Ama had heard of HIV but did not know what it is, how it is transmitted, or how to be protected from the virus. Kofi responded, “It’s a disease, but I don’t know what type of disease it is.” He did not know how people get HIV, but when asked how one can protect one’s self, he responded, “We shouldn’t pick blades from the ground.” I asked him where he learned this information, but he did not know.

## **Emotional Reactions to HIV/AIDS**

I then asked if people with HIV are different from everyone else, and the ten-year-olds responded that they are not different: “we are all the same.” Kofi, however, claimed there was a difference. When I pressed him to explain, he did not answer. In regards to how people with HIV should be treated, Emmanuel said we should not talk to them. Kofi responded, “Those with HIV, we shouldn’t mind them. We should just forget about them.” Ama said she did not know. All of the children’s responses showed a low-level of knowledge about the disease, and they did not name any actual sources of their information, showing that they have not had any formal HIV/AIDS education in the home or at school. However, the stigma of the disease has somehow been impressed upon the two boys, despite their seemingly low exposure to the virus.

## **Communication about HIV/AIDS**

I asked the children who they can talk to about HIV. Emmanuel said he can talk to the founder and owner of the home. The other two said they can speak with no one. However, they all responded “yes” to the question, “Can you talk with the housemothers about HIV?” Their yes/no answers to the questions regarding HIV-positive people being different and communicating with caregivers seemed to be randomly selected based on what they believed I wanted to hear. Based on the fact that the founder of the home specifically works with people living with HIV/AIDS, I was surprised at the children’s minimal knowledge. These children are particularly young, but when compared to peers of same age at the other two orphanages, they know less about HIV/AIDS. The home’s primary aim, which is to give orphans and vulnerable children the opportunity to grow up “normally,” does not take into consideration how the HIV/AIDS stigma may be a barrier to normal childhood. In the summer of 2008 I found that many of these children’s parents died from AIDS, and this information is not disclosed because it is not appropriate for children. Initially, I did not understand what motivated this level of secrecy; now it seems as though disclosing family history of HIV/AIDS is not appropriate because it is stigmatizing. Not only do these children remain ignorant of their personal histories with HIV/AIDS, they are also barred from any knowledge about HIV/AIDS whatsoever. Although this may be a protective measure, it is ultimately ineffective in reducing the stigma of HIV/AIDS, and the silence may actually contribute to the stigma.

## **Interview with a Caregiver**

I then spoke with the head housemother of the home, who had been employed for a year. She told me that before coming to the Children’s Home of Hope, she knew that HIV was a sickness

and that being faithful to one's partner was important in stopping the spread of HIV. She also knew that condoms prevent HIV transmission and that sharing razor blades is dangerous. Furthermore, sharing food with an infected person does not make one susceptible to transmission. Being employed at the Children's Home of Hope did not directly lead to further education about HIV, but since she has been employed, she has attended information sessions about the disease. At the latest information session, she learned that HIV is transferred from one person to another through blood contact. She also learned that people should not share combs. Sharing combs does not directly lead to transmission, but it may be advised not to share personal items in order to take greater hygienic precautions against the spread of disease in general. Children may have open sores or fungal infections on their scalps, and perhaps not sharing combs is practical health advice.

I then asked her if she speaks with the children about HIV, and she said, "Yes, I tell them. I used to tell them that they must be careful about somebody's blade so that it mustn't affect them. You don't know the one who has the virus or who has the sickness, so always you must be careful about things you use." When asked if she counsels children who are affected by HIV, she said she does not; rather she just instructs them practically when necessary. She says it is best to talk freely with the children about HIV, and nothing prevents her from speaking with them about it: "Children are troublesome... Everything they get, they put it in their mouth. And they don't know whether it is good or bad. So if you don't tell them, they will go and eat what they mustn't eat. In the future, they will be in trouble." I asked her what information is appropriate for children in regards to HIV, and she emphasized avoiding razor blades, sharp objects, and blood contact.

At this point in the interview, I asked her what it means to her if someone has HIV. She responded that it means the person has a virus and needs to go to the hospital for treatment. She then said that people with HIV are “shy about it.” She said that even if a person is naturally lean, others might think that person has the virus, and she emphasized several times that people with the virus keep it private. In response to the question, “Are people with HIV different from other people?” she said, “Yes, different from other people. Those having it are shy about their friends. They know that you will point your fingers on them, so they are shy about it, unless you talk to them and go to the hospital.” Her response implies that people living with HIV are ashamed and fear being stigmatized in their communities. I asked how people in the surrounding community feel about those with HIV, and she answered, “I don’t know. Everybody is their own character. As for me, they have told us what HIV is and... you can communicate with the person. It doesn’t affect you unless the blood gets to you.” For her, attitude toward people with HIV seems to be a matter of education. Because she is aware of the various means of HIV transmission, she does not seem to have any strong feelings about those living with HIV. I asked if she can distinguish whether or not a person has HIV, and she said that the person may be ill often, making frequent trips to the hospital for various aches and illnesses. However, she also noted that some people are simply sickly, and their pains are unrelated to HIV. Finally I asked if she has any resources to help her care for children who are affected directly and indirectly by HIV, and she said that she does not.

## Summary of Results

Initially, the housemother's responses led me to believe that people in the community shame those living with HIV, but later she implied that people's attitudes depended on their level of education about the disease. In regards to communicating with children about HIV, it seems that she does not necessarily engage in conversations to actively educate the children about HIV; rather, she instructs them in practical ways regarding hygiene and safety. Having observed the home, there is little time for the housemother to verbally interact with children unless she is disciplining them. Running a functional home for twenty children leaves little time for one-on-one interaction or educational moments. As long as the children are instructed not to share personal items, HIV may not seem like a relevant topic of conversation or a possible threat. The children I interviewed had minimal knowledge about HIV, and their responses were somewhat less developed than children in their same age groups at the other orphanages. The ten-year-olds' responses were not terribly different from the other ten-year-olds', but the fourteen-year-old boy seemed to have less knowledge than his peers. Furthermore, their general attitudes about life at the orphanage, friendships, and their futures were less positive than the attitudes of their peers at the other two orphanages.

Because the home has been established for only two years, there is less consistency regarding financial resources, the housemother, and daily life. The children have had three housemothers in three years, and each housemother's rules and expectations are different. The organization's mission is to normalize these children's lives and realistically, these children are living as other children in the community do, meaning that sometimes they live without electricity, food, or water. Because daily life is a struggle, HIV/AIDS education does not seem to be a priority, especially for a group of young children.

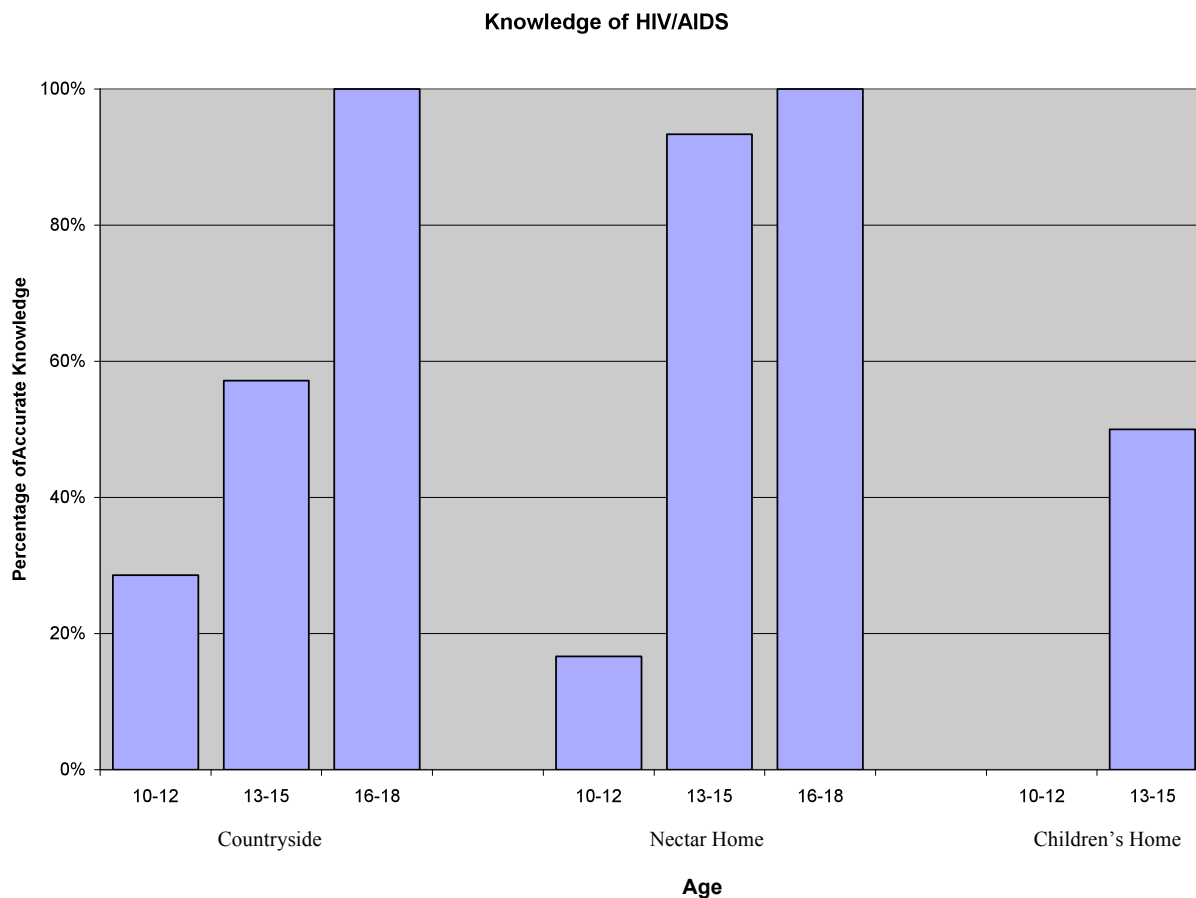
# Conclusion

The results of this study regarding communication between caregivers and orphans about HIV/AIDS at three orphanages in Ghana are functional in both expected and unforeseen ways. This study provides concrete results about children's quality of life at the homes, their knowledge of HIV/AIDS, their emotional reactions to the disease, and information about whom they are communicating with about HIV/AIDS. This study also took place at a very critical time for Ghanaian orphanages as the Care Reform Initiative is being implemented to close down institutionalized living arrangements for children. Questions that were designed to ease the participants into the interview process have provided valuable insight into the quality of life at these particular children's homes, providing evidence that these children's needs for nourishment, education, and love are being met in the institutions.

## HIV/AIDS Education

The results of the interviews indicated several positive correlations between knowledge of HIV/AIDS and other characteristics of children, which include age, English proficiency, and gender. As to be expected, older children know more about HIV/AIDS than younger children. Figure 1.1 on page 53 was derived by evaluating each of the participant's responses as exceptional, neutral, or poor regarding the following three questions: What is HIV? How does one get HIV? How can one protect one's self from getting HIV? Participants' responses were considered exceptional if they could name HIV as Human Immunodeficiency Virus or simply as a virus, as well as if they mentioned "no cure" or "deadly" when asked to define HIV.





**Figure 1.1:** This graph shows the percentage of positive responses given by participants, divided into age groups. Neutral responses are not accounted for in this graph.

Participants who referred to HIV generally as a sickness or a disease received neutral marks, and children who did not know or gave incorrect responses were rated as poor. Participants who were able to give means of transmission other than “sharing blades” were rated as exceptional for the question: How does one get HIV? Children who only mentioned razor blades received neutral marks, and those who did not know or gave incorrect responses were rated as poor. Any concrete example of how one protects one’s self from HIV was given an exceptional rating. Children who suggested going to the hospital or cleaning up were given neutral marks, and incorrect responses or no response was considered to be poor. Responses were then divided into the following age groups: ten to twelve, thirteen to fifteen, and sixteen to eighteen. For each age

group at each home, I divided the number of exceptional responses by the total number of exceptional and poor responses in order to derive a ratio of exceptional to poor responses, illustrated by Figure 1.1. The older the participant, the more likely the child has more accurate information about HIV/AIDS. All of the participants in the sixteen to eighteen age category gave accurate, exceptional responses to all of the questions. Participants between the ages of thirteen and fifteen gave more exceptional responses than poor responses. Children in the ten to twelve age category gave fewer exceptional responses than poor responses, and the youngest children at the Children's Home of Hope did not receive exceptional ratings for any of their responses.

In a related sense, participants who conducted their interviews in English received more exceptional ratings for their knowledge of HIV/AIDS. The general trend is that older children are more likely to speak English. None of the children aged ten to twelve spoke English, and all of those in the sixteen to eighteen age category conducted their interviews in English. Participants, aged thirteen to fifteen, had mixed levels of English proficiency as well as knowledge about HIV/AIDS. Examining the individuals in this age group shows that those with greater skill in English also know more about HIV/AIDS. Those who were interviewed in English gave responses that received 92 percent exceptional ratings and eight percent neutral marks. The one participant who was interviewed partly in English gave 67 percent exceptional responses and 33 percent neutral responses. Those who did not speak English gave 50 percent exceptional responses, 33 percent neutral responses, and 17 percent poor responses. This shows a unique relationship between English proficiency and knowledge of HIV/AIDS that is not entirely confounded with age. Those who speak better English generally attend private schools or are in upper-level classes. This trend was apparent during the interviews at Nectar Home,

because the children coming home from private schools arrived at the home late in the day and conducted their interviews in English.

Finally, this research seems to show that females know more about HIV/AIDS than males. Eighty-six percent of the females conducted their interviews in English, and they gave 76 percent exceptional responses. Meanwhile, only 20 percent of the males conducted their interviews in English, and boys gave 40 percent exceptional responses. It is unclear whether the females' superior knowledge about HIV/AIDS has any relation to their gender, despite the correlation, because they also have superior English skills. The females interviewed tended to be some of the more educated individuals. In general, their responses were more thorough; this information contradicts the results of the study by Anarfi and Antwi, which shows that females tend to have more misconceptions about STDs. Three females in this study mentioned blood transfusions as means of transmission; not one male considered this. The average age of the females was 14.6 and the average age of the males was 12.9. Therefore, the females' greater level of knowledge could also be related to being older and in more advanced classes.

Having considered some general trends regarding HIV/AIDS knowledge, I would also like to consider the participants' actual responses to the interview questions. One-hundred percent of participants had heard of HIV, and 73 percent were able to identify HIV as a virus, a sickness, or a disease. Three respondents (or 14 percent), age thirteen, sixteen, and eighteen, were able to identify HIV by its full name, Human Immunodeficiency Virus. When asked to define HIV, only eighteen percent either gave incorrect means of transmission, did not know what HIV is, or gave incorrect definitions of the virus. All of these participants were under the age of fourteen.

When asked specifically about transmission, 45 percent of respondents mentioned sharing razor blades and 45 percent identified sex or an affair as means of transmission. Only two of the ten respondents who mentioned sharing razor blades specified that one must not share blades *with an infected person*. Only one of the ten respondents who mentioned sex or an affair specified sex *with an infected person*, and two people specified unprotected sex. One of the ten specified sex with a stranger as a means of transmission, alluding to the fear of the different other. As mentioned in the introduction, there is a misconception in Ghana that sex with familiar people or at least familiar-looking people is safe sex. Two of the respondents did not specify sex at all, euphemistically using the term “affair.” Although this term has certain connotations, the fact that these two identified it as a means of transmission does not necessarily indicate their full understanding that unprotected sex with an infected person is what makes one vulnerable to transmission. They could simply be referring to the social taboo of infidelity, emphasizing the importance of faithfulness but not necessarily invoking the notion of protected sex. The remaining four simply stated that sex is a means of transmission. It is unclear whether these four believe that any type of sex could lead to HIV/AIDS transmission or if they were simply being broad in their answers. When asked about protecting one’s self from HIV transmission, an equal number of respondents (four) mentioned condoms as those who mentioned abstinence. Twenty-three percent of the participants did not know how one gets HIV, and fourteen percent gave incorrect responses to the question about transmission. Therefore, over one third of the participants in this study currently have no useful knowledge of HIV/AIDS.

When asked about the source of their information, 36 percent of respondents in this study identified school and 36 percent the Home. Therefore, this study shows that the original assumption that sex education is limited in Ghanaian schools is not entirely accurate. Although

the style of sex education is unclear, the older participants are certainly receiving information from their schools about HIV/AIDS that they are then able to relay accurately and in detail. At Countryside, a significant number also mentioned visitors, who purposely came to the home to educate its residents about HIV/AIDS, as the source of their information. Some of these visitors were Western volunteers, and many were Ghanaians. These Ghanaian groups of educators and activists and the HIV/AIDS club at one of the respondent's schools illustrate that HIV/AIDS education is being taken up by the country and is not solely a Western endeavor, as much of the literature that exists on this topic indicates.

The majority of respondents who mentioned the Home as their source of information live at Nectar Home. This is not surprising, considering the Home's mission to educate about HIV and to eliminate the stigma of the disease. This information is also useful in analyzing the children's emotional responses to the disease, which were extracted by the questions, "Are people with HIV/AIDS different than everybody else?" and "How should people with HIV be treated by other people?" Not one participant at Nectar Home mentioned anything remotely stigmatizing in their responses; rather they indicated that one should make those with HIV happy by playing with them and being around them. Many also cautioned that one should protect one's self by not using personal items of those with HIV. When asked if people with HIV are different, every child at Nectar Home who responded affirmatively then clarified that people with HIV are different because they are at risk, they grow lean, or simply because they have HIV. Eight of the nine respondents indicated that those with HIV are different in one of these ways.

At Countryside and Children's Home, where many of the respondents indicated that people with HIV/AIDS are not different, participants were also more likely to stigmatize

HIV/AIDS. Sixty percent of the participants at Countryside somehow stigmatized HIV in their responses, and 67 percent stigmatized HIV at the Children's Home of Hope. Many of these children indicated that one should not go near people living with HIV, that one should forget about them, or even that they are bad people. In some cases, there was a disconnect between actual knowledge of the disease and emotional meanings the children attached to HIV/AIDS. Even if they understood the mechanics of contracting HIV, they may still express the belief that infected people are somehow bad.

The caregivers at Countryside indicated that they are open to discussing HIV/AIDS with children and that they feel it is important to talk freely about the disease. One of the mothers specifically said that it is important to discuss sex with the children so that their main source of sexual knowledge is not their peers. Many respondents showed awareness that sex is a means of HIV transmission. Meanwhile, one of the mothers indicated that the surrounding community stigmatizes those with HIV, and she illustrated her point by saying that even the children of a person with HIV may be avoided or scorned. This attitude has seemingly permeated Countryside Children's Welfare Home. Despite the housemothers' willingness to discuss HIV/AIDS with the children, they are not actively pursuing discussions about the disease, and the HIV/AIDS stigma persists among the residents of the home.

The initial event that inspired this study was being informed that children are not told their parents died from AIDS because it is "inappropriate" information for children. However, all of the caregivers insisted that they are open with the children about HIV/AIDS. This study shows that concrete information about HIV/AIDS, even when the information is about sexual behavior, is considered appropriate to share with children, but the stigma of HIV/AIDS is still so strong that it is not appropriate to tell the children that their parents died from AIDS. Just

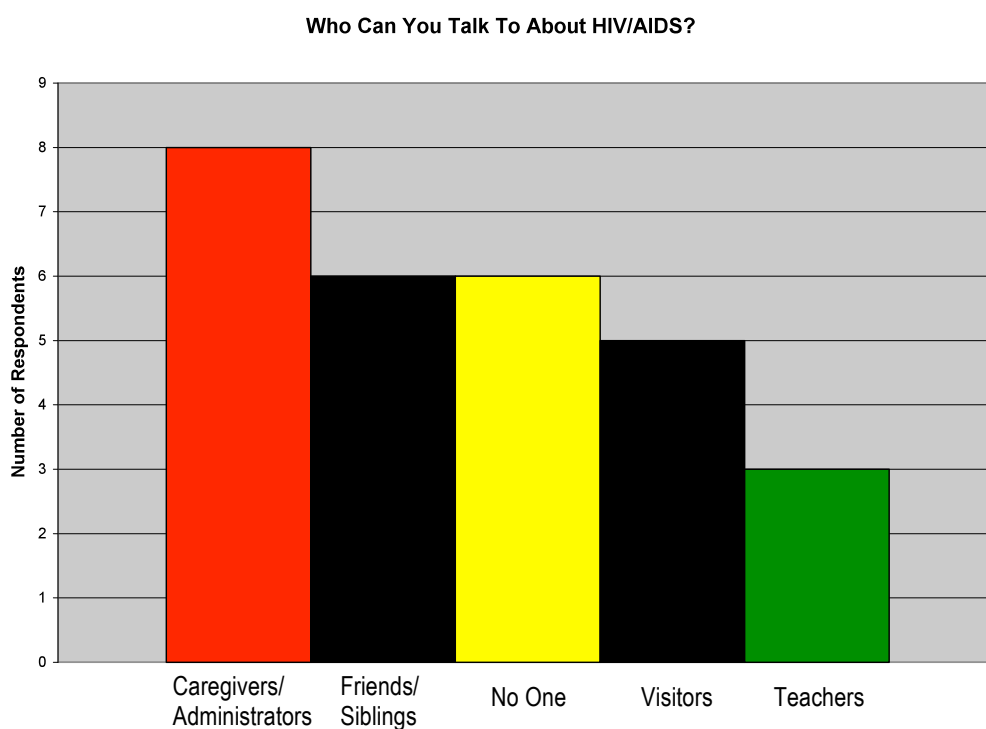
because a child understands the mechanics of contracting HIV does not mean that the child disassociates emotional meanings from the virus.

According to the housemothers, not one of the children at Countryside is HIV positive, so it may not seem important to discuss how to behave toward one with HIV. At Children's Home of Hope, the participants were much younger and had very limited knowledge of the disease. The caregiver was highly informed about HIV/AIDS and indicated that she instructs the children accordingly, making sure they do not share sharp instruments. Despite the caregivers' high level of understanding and the children's very limited actual knowledge, two of the three children invoked the HIV stigma and stated that one should avoid those with the virus. Therefore, the stigma is thriving in these rural communities. For many of the children at Countryside and Children's Home, their level of knowledge about the disease is irrelevant to their emotional understandings of the disease. The oldest and most educated participants at Countryside were the few who did not invoke the stigma.

This research project was developed with the intention of investigating transgenerational communication about HIV/AIDS. Figure 1.2 shows that caregivers and administrators were mentioned by eight of the participants as people they speak with about HIV/AIDS. Six participants mentioned friends or siblings, and six participants said they speak with no one about HIV/AIDS. Five mentioned visitors, and three said teachers. When asked if they can speak with caregivers about HIV/AIDS, 20 out of 22 participants answered, "yes."

All four of the caregivers I interviewed were very open to speaking with the children about HIV/AIDS. The housemothers at Countryside presented themselves as less likely than the mothers at Nectar Home and Children's Home to approach a child with the intention of discussing HIV, but they were open to the topic if it were to come up. All of the housemothers

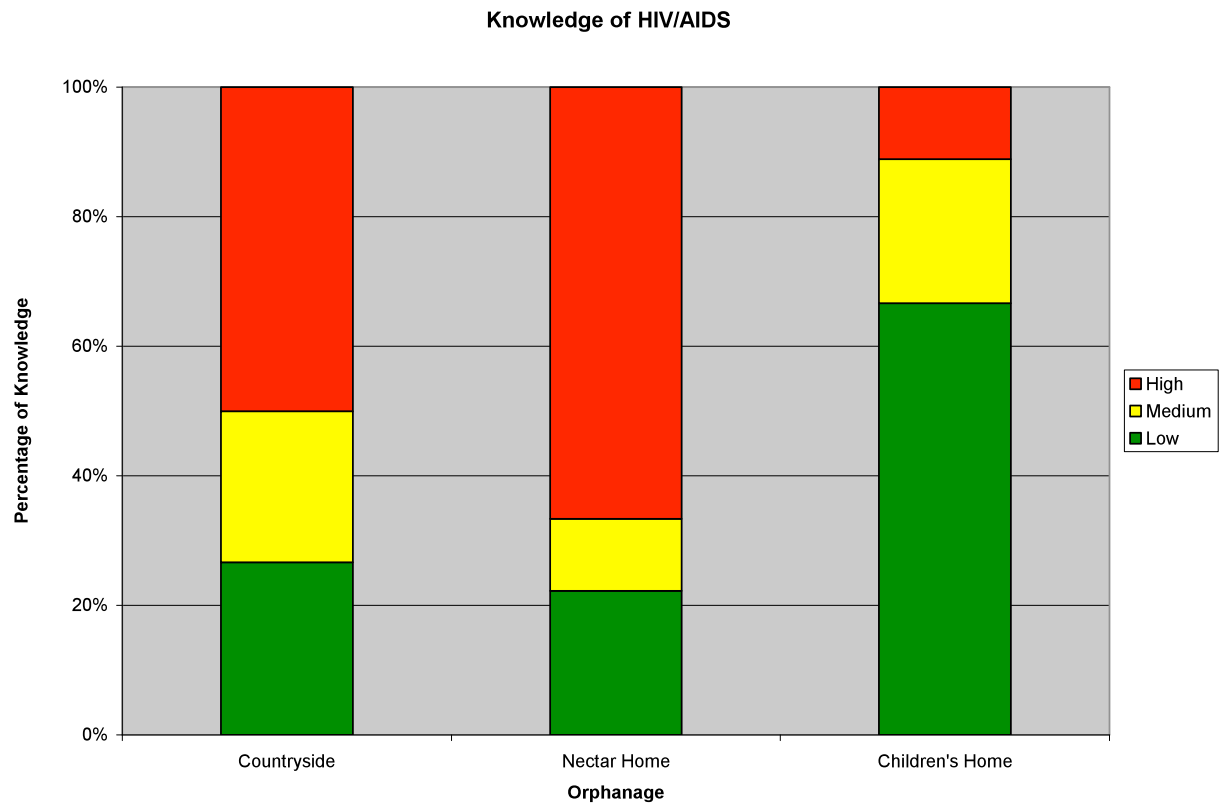
gave accurate means of transmission and seemed sympathetic to those with the virus. Two of the housemothers (one at Countryside and one at Nectar Home) said that it is important to discuss sex with children at an early age, and the other two mothers felt that discouraging shared razor blades and sharp objects was an appropriate topic of conversation for children. All of the housemothers felt that it is important to talk freely about the disease, and nothing would prevent them from discussing HIV with the children. Although these women are educated about the disease and sympathetic to those who are infected, they allude to the stigma of HIV in other ways. One housemother said that if she found out a child was HIV positive, she would hide this information from the other children. Another mother said she would comfort such children because they would feel as though they were not a part of human kind any longer. Three of the four women alluded to the stigmatizing attitude of the surrounding communities.



**Figure 1.2:** This graph measures how many participants mentioned the above groups as people they speak with about HIV/AIDS.



The children at Nectar Home never once invoked the HIV stigma, and they were also the most educated about HIV/AIDS. Figure 1.3 shows the percentage of exceptional, neutral, and poor knowledge about HIV/AIDS at each orphanage, as indicated by the categories: high, medium, and low. Nectar Home has been seemingly successful at both reducing the stigma of HIV/AIDS and educating its population about the disease. Children at Countryside are also well-informed, although they have attached emotional meanings to the virus, often stigmatizing those with HIV/AIDS. Participants from the Children's Home of Hope had very little knowledge about HIV/AIDS, and they were also much younger on average than participants from the other two homes.



**Figure 1.3:** This graph shows percentages of high, medium, and low levels of knowledge of HIV/AIDS at each orphanage.

This study disproves the original assumption that the HIV/AIDS stigma in Ghana results in the stifling of information about HIV/AIDS through limited and even misleading sex education both in school and in children's homes. The results of the interviews illustrate how HIV/AIDS education can coexist with the stigmatization of HIV/AIDS. However, Nectar Home provides an example of an institution that intentionally and successfully reduces the HIV/AIDS stigma through HIV/AIDS education and by providing a nurturing space for those who are infected. The Home does not exclusively house HIV positive children, thereby creating advocates among the other children, who are exposed to the realities of the disease through their peers' experiences. Furthermore, prior assumptions about the inadequacy of institutional care are challenged by the high quality of life reported by the participants of this study, complicating the basic assumptions of the current Care Reform Initiative.

## **The Care Reform Initiative**

The director of Countryside Children's Welfare Home asserted that Ghana is not like the UK or the US and should not be expected to comply with Western standards; Nectar Home's population had been reduced in size by fifty percent when I arrived at the home; and the director of Children's Home of Hope was hastily scraping funds together to update the home in order to meet the latest standards. Orphanage directors all over Ghana are panicking as the Care Reform Initiative is being implemented throughout the country. According to the Ghanaian Department of Social Welfare, "The Care Reform Initiative to update and enforce the Regulations and Standards for the Operation of Residential Care Setting in Ghana is a joint venture between the Department of Social Welfare and OrphanAid Africa.... The aim of the program is to ensure that

institutional care is used as a last resort...”<sup>70</sup> The objectives of this program are to move orphans and vulnerable children into foster homes and to close down badly run children’s homes. This program was inspired by the UN Committee of the Rights of the Child (1990), which seeks to standardize global treatment of children as individuals with rights whose best interests must be considered at all times.

The Care Reform Initiative, which took affect in 2006, is largely funded by a US-based NGO, OrphanAid Africa. The organization was founded in 2002 by Lisa Lovatt-Smith, an author of books regarding design and photography and an editor for *Vogue* magazine. After volunteering with her daughter at a Ghanaian children’s home in 2002, she was inspired to start an organization to benefit orphans and vulnerable children in Ghana. Based on the belief that institutional living environments are inferior to family arrangements, the motto of the organization is “Every child deserves a family.” Both the Department of Social Welfare and OrphanAid Africa emphasize the importance of the family structure in Ghana and promote foster care and kinship networks in place of institutions. The Care Reform Initiative operates on the assumption that institutions employ culturally inappropriate ways of raising children.

The Department of Social Welfare states that many of the children living in such homes are not orphans at all; rather their families are not able to care for them. However, relying on the extended family to care for more children is not necessarily the solution to this problem. Urbanization has divided families and poverty hinders families’ abilities to provide for additional children. Furthermore, foster children are not always treated as members of the family; they may take on additional household responsibilities, and sometimes the family cannot afford school fees for foster children.

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<sup>70</sup> Government of Ghana, Ministry of Manpower, Youth and Employment, and Department of Social Welfare. March 2007. “Standards for Operation of Residential Care Settings in Ghana.” 3<sup>rd</sup> working draft.

The Department of Social Welfare fears dependency on institutions as the only means of providing care and support for orphaned and vulnerable children. Furthermore, there is a fear of exploitation; anyone can open up a private orphanage and solicit funds. Orphanages in the developing world seem to have an appeal for Westerners, so opening an orphanage can easily be an entrepreneurial endeavor rather than a heartfelt call to action. But a reactive call to kinship fostering systems may not be the answer. This reform is based on the notion of children's rights and considering their best interests. One such right as stated in the Children's Act of 1998 is "...the right to life, dignity, respect, leisure, liberty, health, education and shelter from his parents."<sup>71</sup> Unfortunately, not every family has the capability to provide all of this for their children, and in some cases, institutions may provide what the family cannot.

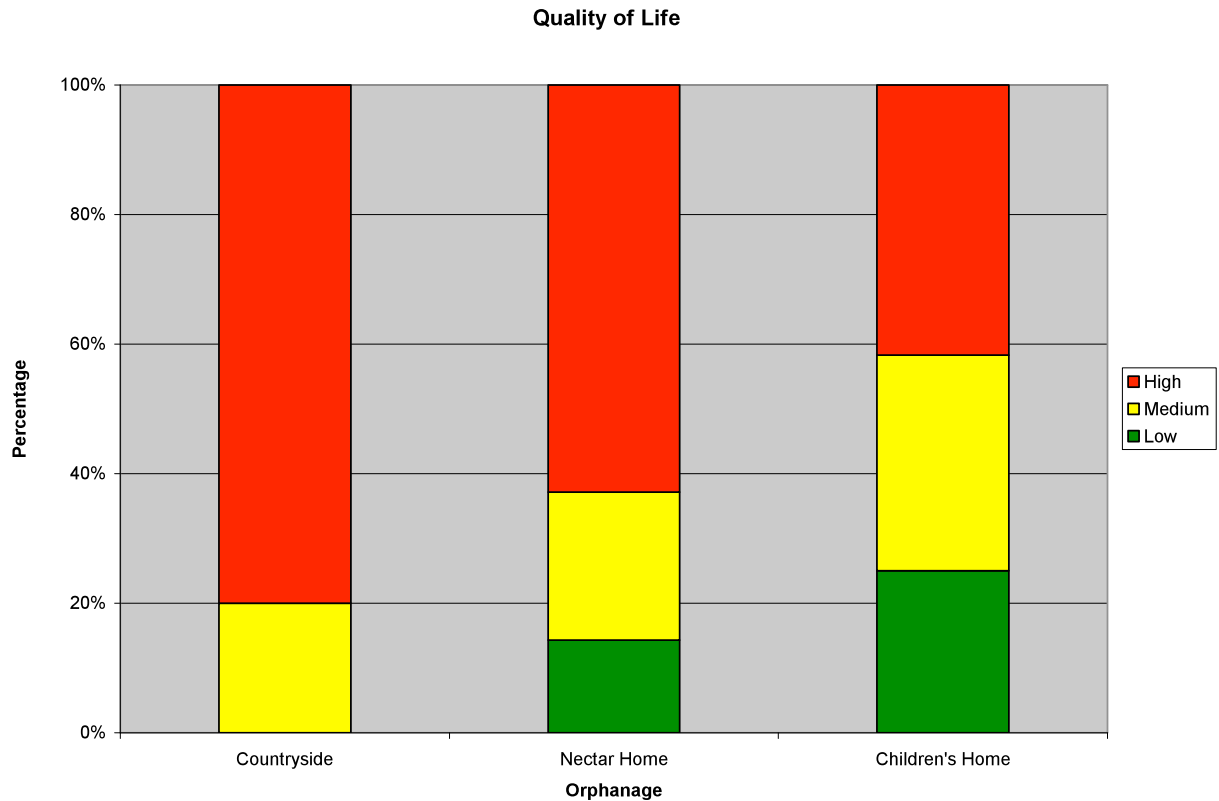
This study provides evidence that institutions can provide health, education, and shelter when families cannot. Figure 1.4 breaks down the participants' responses to four questions: What was it like for you when your parents passed away? Is your life different than the lives of kids who don't live in the orphanage? How? Do you have friends and do your friends support you? How do you feel about your future? Each response was rated as high, medium, or low regarding quality of life. The graph shows the percentage of high, medium, and low responses for each orphanage. Seventy-two percent of participants feel that their lives are better than the lives of children in the surrounding community, explaining that they have access to food, clothing, education, care, and guidance when children in the community do not. Fifty-five percent of the children said that the home feels like a family. One-hundred percent of those interviewed have plans for their futures and 82 percent feel that they have the resources to meet their goals. Children at the homes are being sponsored for higher levels of education; more than half of the children at Children's Home of Hope are sponsored to attend private school; several

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<sup>71</sup> The Parliament of the Republic of Ghana, *Children's Act of 1998*. Part One Section Six.

of those I interviewed at Nectar Home attend private school because of private scholarships, and one of the eighteen-year-olds is even attending college this upcoming year. Countryside provides education not only to its own residents but also to the children in the surrounding community. Children benefit from the networks that the homes have established. Figure 1.4 shows that the quality of life at Countryside and Nectar Home are especially high. Both of these homes are well-established and funded, maintaining good rapport with donors and volunteers.

Private, well-run homes meet a need in Ghana. It is impossible to place all needy children in appropriate family situations while truly considering the children's best interests. At Countryside and Nectar Home, it is in most of the children's best interests to live at the homes. Abuse and exploitation are legitimate fears regarding children's homes, but abuse and exploitation are also possible when placing a child into a foster family. Creating and enforcing uniform expectations for these homes is certainly advisable, but the expectations must also be reasonable by Ghana's own standards. Internationally enforced expectations may not be culturally appropriate or feasible given Ghana's infrastructure and resources. Unfortunately, international aid may be contingent on Ghana's compliance with outside expectations.



**Figure 1.4:** This graph shows the percentage of responses indicating high, medium, and low quality of life at each orphanage.

OrphanAid would not likely fund a project dictated by Ghana's government unless it found the policy to be in accordance with its own goals and visions. Therefore, Ghana's Department of Social Welfare may indeed feel that the foster care system needs government attention, but undue American influence may direct the project in more extreme directions because funding is conditional upon conforming to the American NGO's vision.

This is only the beginning of a conversation about appropriate living arrangements for orphans and vulnerable children in impoverished, developing nations. An ideal, uniform protocol is not a possibility. Living as foster children in families might meet some of children's needs, such as culture, identity, and intimate relationships with parental figures. Large

institutional facilities may meet other needs, such as nourishment, education, and access to resources. Conversations about the child's best interest are limited in this framework, which requires a trade-off between intimate family life and access to education and healthcare. AIDS orphans who have been removed from Nectar Home still travel back to the home for a meal each day, and many were forced to drop out of school. Furthermore, their families do not have access to necessary medical resources. Nectar Home is an especially unique case. As shown previously, the Home has been successful in providing a safe, loving space for AIDS orphans, who are not only physically vulnerable but are also emotionally vulnerable to stigmatization.

Ghana's intention to solve such difficult issues is commendable, but greater thought and research are necessary before simply closing down functional institutions like Countryside and Nectar Home. These institutions are not only beneficial to their residents; they also provide services for the surrounding communities. Even the children at Children's Home of Hope are in some ways better off than their peers in the community. The nuanced complications of this issue must be considered. For now, further investigation is necessary. Each institution must be treated as a unique case, and if the child's best interest is truly paramount, many of these homes will continue to operate. Outside funding will be welcome to assist in enhancing the institutional environments and enforcing uniform standards, such as requiring homes to provide fiscal reports to government authorities and training an appropriate number of quality staff members. Outside interference that is premature and forces a complicated situation into a simplified framework will fail, because blindly closing well-run institutions and hastily placing children in inadequate homes will not alleviate the anxiety over the increasing social burden of vulnerable children in Ghana.

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